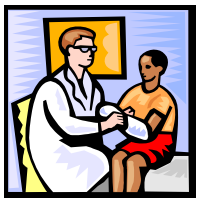

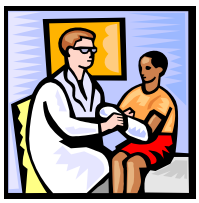

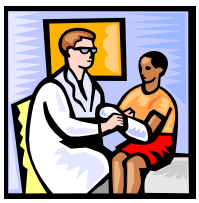

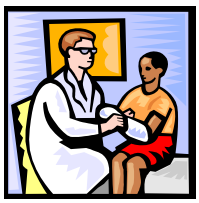

Rural Health Clinics and Federally Qualified Health Centers

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

This publication supersedes all previous Rural Health Clinic (RHC) and Federally Qualified Health Center (FQHC) handbooks. Published by the Montana Department of Public Health & Human Services, May 2006.

My Medicaid Provider ID Number:

MONTANA
Department of Public Health & Human Services

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Key Contacts

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Provider Enrollment

For enrollment changes or questions:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Send written inquiries to:
Provider Enrollment Unit
P.O. Box 4936
Helena, MT 59604

Provider Relations

For questions about eligibility, payments, denials, general claims questions, PASSPORT questions, or to request provider manuals or fee schedules:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send e-mail inquiries to:
MTPRHelpdesk@ACS-inc.com

Send written inquiries to:
Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Medicaid Client Help Line

Clients who have Medicaid or PASSPORT questions may call the Montana Medicaid Help Line:

(800) 362-8312

Send written inquiries to:
PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Client Eligibility

For client eligibility, see the *Client Eligibility and Responsibilities* chapter in the *General Information For Providers* manual.

Claims

Send paper claims to:
Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena

Send written inquiries to:
ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

PASSPORT Program Officer

Send written inquiries to:
PASSPORT Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Provider Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *Introduction* chapter in the G*eneral Information For Providers* manual.

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

EDI Technical Help Desk

For questions regarding electronic claims submission:

(800) 987-6719 In- and out-of-state
(850) 385-1705 Fax

Send e-mail inquiries to:
MTEDIHelpdesk@ACS-inc.com

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

CLIA Certification

For questions regarding CLIA certification, call or write:

(406) 444-1451 Phone
(406) 444-3456 Fax

Send written inquiries to:

DPHHS
Quality Assurance Division
Certification Bureau
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

RHC and FQHC Program Officer

(406) 444-4540 Phone
(406) 444-1861 Fax

Send written inquiries to:

RHC and FQHC Program Officer
DPHHS
Hospital and Clinic Services Bureau
P.O. Box 202951
Helena, MT 59620-2951

Direct Deposit Arrangements

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below.

(406) 444-5283

Chemical Dependency Bureau

For coverage information and other details regarding chemical dependency treatment, write or call:

(406) 444-4540 Phone
(406) 444-9389 Fax

Send written inquiries to:

Chemical Dependency Bureau
Addictive and Mental Disorders Division
DPHHS
P.O. Box 202905
Helena, MT 59620-2905

Lab and X-ray

Public Health Lab assistance:
(800) 821-7284 In state
(406) 444-3444 Out of state and Helena

Send written inquiries to:
DPHHS Public Health Lab
1400 Broadway
P.O. Box 6489
Helena, MT 59620

Claims for multiple x-rays of same type on same day, send to:
DPHHS
Lab & X-ray Services
Health Resources Division
P.O. Box 202951
Helena, MT 59620

Multiple Visits

Claims for multiple visits on the same day, send for review to:
DPHHS
Hospital and Clinic Section
Health Resources Division
P.O. Box 202951
Helena, MT 59620-2951

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):
(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers are expected to refer to their specific provider manual for prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for specific services, contact SURS at:
(406) 444-6977 Phone
(406) 444-0778 Fax

Send written inquiries to:
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Mountain-Pacific Quality Health Foundation

For questions regarding prior authorization for transplant services, private duty nursing services, medical necessity therapy reviews, and emergency department reviews:

Phone:
(800) 262-1545 X5850 In and out of state
(406) 443-4020 X5850 Helena

Fax:
(800) 497-8235 In and out of state
(406) 443-4585 Out of state and Helena

Send written inquiries to:
Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.
(800) 770-3084 Phone
(800) 639-8982 Fax
(800) 247-3844 Fax

First Health Services
4300 Cox Road
Glen Allen, VA 23060

Key Web Sites

Web Address	Information Available
Provider Information Web Portal www.mtmedicaid.org or www.dphhs.mt.gov/medicaid/	• Medicaid information • Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • Electronic billing information • Newsletters • Key contacts • Links to other websites and more • Log in to Montana Access to Health
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)
Centers for Disease Control and Prevention (CDC) website www.cdc.gov/nip	Immunization and other health information
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider services • EDI support • Enrollment • Manuals • Software • Companion guides • FAQs • Related links

MONTANA
Department of Public Health & Human Services

Introduction

Thank you for your willingness to serve clients of the Montana Medicaid program and other medical assistance programs administered by the Department of Public Health and Human Services.

Manual Organization

This manual provides information specifically for rural health clinics (RHCs) and federally qualified health centers (FQHCs). Materials have been consolidated whenever possible. Specific mention will be made when information is for both RHCs and FQHCs (B), RHCs only (R), and FQHCs only (F). In this manual, the term clinic refers to both RHCs and FQHCs.

Additional information for providers is contained in the separate *General Information For Providers* manual. Each provider is asked to review both manuals.

A table of contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. There is a list of *Key Contacts* at the beginning of each manual. We have also included a space on the back side of the front cover to record your Medicaid Provider ID number for quick reference when calling Provider Relations.

Manual Maintenance

Manuals must be kept current. Changes to manuals are provided through notices and replacement pages. When replacing a page in a manual, file the old pages and notices in the back of the manual for use with claims that originated under the old policy.

Providers are responsible for knowing and following current laws and regulations.

Rule References

Providers must be familiar with all current rules and regulations governing the Montana Medicaid program. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails. Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*). In addition to the general Medicaid rules outlined in the *General Information For Providers* manual, the following rules and regulations are also applicable to rural health clinics and federally qualified health centers:

- Code of Federal Regulations (CFR)
  - 42 CFR 405.2400 - 42 CFR 405.2472
- Montana Codes Annotated (MCA)
  - MCA 53-2-201, 53-6-101, 53-6-111 and 53-6-113
- Administrative Rules of Montana (ARM)
  - ARM 37.86.4401 - 37.86.4420

Claims Review (MCA 53-6-111, ARM 37.85.406)

The Department is committed to paying Medicaid provider's claims as quickly as possible. Medicaid claims are electronically processed and usually are not reviewed by medical experts prior to payment to determine if the services provided were appropriately billed. Although the computerized system can detect and deny some erroneous claims, there are many erroneous claims which it cannot detect. For this reason, payment of a claim does not mean that the service was correctly billed or the payment made to the provider was correct. Periodic retrospective reviews are performed which may lead to the discovery of incorrect billing or incorrect payment. If a claim is paid and the Department later discovers that the service was incorrectly billed or paid or the claim was erroneous in some other way, the Department is required by federal regulation to recover any overpayment, regardless of whether the incorrect payment was the result of Department or provider error or other cause.

Getting Questions Answered

The provider manuals are designed to answer most questions; however, questions may arise that require a call to a specific group (such as a program officer, Provider Relations, or a prior authorization unit). The list of *Key Contacts* at the front of this manual has important phone numbers and addresses pertaining to this manual. The *Introduction* chapter in the *General Information For Providers* manual also has a list of contacts for specific program policy information. Medicaid manuals, notices, replacement pages, fee schedules, forms, and much more are available on the Provider Information website (see *Key Contacts*).

Covered Services

General Coverage Principles

Medicaid covers almost all services provided in a rural health clinic (RHC) or federally qualified health center (FQHC) when they are medically necessary, including preventive primary services in FQHCs. This chapter provides covered services information that applies specifically to RHCs and FQHCs. Like all health care services received by Medicaid clients, these services must also meet the general requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual.

As a condition of participation in Medicaid, a clinic must meet all requirements generally applicable to Medicaid providers. The health professionals must meet the same requirements as if enrolled themselves, including licensure, certification, or registration for his or her provider type. Each clinic provider also must maintain a current Medicaid provider enrollment.

Clinic services are subject to all rules, except level of reimbursement, which are applied by the Medicaid program to those services when performed in other settings. Clinics have the same limits on amount, scope and duration of services covered by the Medicaid program such as medical necessity requirements and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program requirements and restrictions.

Service Settings

Clinic services are covered when provided in outpatient settings including the clinic, other medical facility (including a dental office) or a patient's place of residence. A patient's place of residence may be a nursing facility or other institution used as the patient's home. Clinic services are covered off-site as long as the service is normally furnished within the scope of the clinic's professional services. Services provided off-site are part of the clinic benefit if the provider has an agreement with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic doesn't compensate the provider for services provided off-site, the clinic may not bill Medicaid for those services.

FQHCs must not bill in the hospital setting. RHCs may bill in the hospital setting but not for inpatient surgeries and inpatient deliveries.

FQHC providers that perform services in a hospital setting must bill the service on a CMS-1500 form using their own provider number. RHC providers who perform inpatient surgeries or deliveries must unbundle the service and bill for the surgery (using modifier 54) or delivery only (procedure codes 59409 and 59514) on a CMS-1500 using their own provider number.

Pre- and post-visits at the clinic are billed by the clinic on a UB-92 as a core service.

Satellite Clinics

If clinic services are furnished at permanent units in more than one location, each unit is independently considered for approval as a clinic, unless prior approval was granted by CMS, to operate both locations under one provider number. To be considered a "satellite clinic," both sites must share medical staff, office staff, and/or administrative staff. DPHHS must be notified in writing of approval by CMS to operate under one provider number prior to billing for services at the satellite clinic.

Clinic Covered Core Services

The following are covered core services in RHCs (R), FQHCs (F), or both (B) and may be billed as a visit when there is a face-to-face encounter with the patient:

- B—Physician services
- B—Nurse practitioner, nurse specialist, certified nurse midwife or physician's assistant services.
- B—Clinical psychologist, clinical social worker and licensed professional counselor services
- B—Dentist services
- R—Visiting nurse (see "Coverage of Specific Services" later in this chapter)
- F—Preventive primary services (does not include eyeglasses, hearing aids, or preventive dental), but does include:
  - Perinatal care for high-risk patients
  - Tuberculosis testing for high-risk patients
  - Risk assessment and initial counseling regarding risks.

Services and supplies furnished as incident to the above providers (by non-core providers such as lab techs, radiologists, LPNs, etc.) are included in your rate but are not billable as a stand-alone visit even if the service is performed on a separate day from the core visit. They include:

- B—Furnished as an incidental, although integral, part of the physician's or mid-level practitioner's professional service (i.e. influenza vaccine/administration).

- B—Of a type commonly rendered without charge or included in the clinic's claim.
- B—Of a type that is commonly furnished in a physician's office or a clinic.
- B—Basic lab services essential to the immediate diagnosis and treatment of the patient.
- B—Furnished under the direct, personal supervision of a physician, mid-level practitioner, psychologist or social worker.
- B—In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic.
- B—Drugs and biologicals that can't be self-administered.
- B—Radiology, including ultrasound
- B—Pharmacist-only visits of any kind
- B—Outreach
- B—Case management
- B—Transportation

The following services (although they are incident-to-service) may be billed as a stand-alone visit provided they are administered by a core provider or an RN (under close personal supervision of a physician):

- B—Pneumococcal influenza vaccinations and administration
- B—Contraceptive injections (such as Depo-Provera)

Dental hygienist services may be billed by clinics as a stand-alone visit provided they are performed by a licensed dental hygienist (under the direct personal supervision of a licensed dentist).

Ambulatory Services

Services other than "core" services that would be covered under the Montana Medicaid program if provided by an individual or entity other than a clinic in accordance with Medicaid requirements. ***These services are subject to any applicable limitations on the amount, scope or duration of services covered by the Medicaid program (i.e. limits on hours for therapy services, medical necessity criteria, etc.).*** Many of these services also require PASSPORT prior authorization and some emergency dental services for adults may require Department authorization. Please check the appropriate Medicaid manual for specific information concerning these services.

- B—Respiratory therapy and inhalation therapy services
- B—Physical therapy services
- B—Occupational therapy services

- B—Audiology services
- B—Dental services
- B—Mental health services

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) (ARM 37.86.2201 – 2221)

The Well Child EPSDT program covers all medically necessary services for children age 20 and under. Providers are encouraged to use a series of screening and diagnostic procedures designed to detect diseases, disabilities, and abnormalities in the early stages.

Some services are covered for children that are not covered for adults, such as the following:

- Nutritionist services
- Private duty nursing
- Respiratory therapy
- Therapeutic family and group home care
- Substance dependency inpatient and day treatment services
- School based services

All prior authorization and PASSPORT approval requirements must be followed. See the *PASSPORT and Prior Authorization* chapter in this manual.

For more information about the recommended well child screen and other components of EPSDT, please see the *Well Child EPSDT* chapter in the *Physician-Related Services* manual.

Non-covered services (ARM 37.85.207)

The following is a list of services not covered by Medicaid. Some of these services may be covered under the EPSDT program for children age 20 and younger based on medical necessity or for individuals covered under the Qualified Medicare Beneficiary (QMB) program (see the *Eligibility* chapter in the *General Information For Providers* manual).

- Acupuncture
- Allergen immunotherapy services
- Chiropractic services
- Dietician/nutritional services
- Massage services
- Dietary supplements
- Homemaker services
- Infertility treatment

- Delivery services not provided in a licensed health care facility unless as an emergency service
- Naturopath services
- Services provided by surgical technicians who are not physicians or mid-level practitioners
- Services considered experimental or investigational
- Exercise programs and programs that are primarily educational, such as:
  - Cardiac rehabilitation exercise programs
  - Pulmonary rehabilitation programs
  - Nutritional programs
  - Independent exercise programs (e.g., pool therapy, swim programs, or health club memberships)
- Services that are not medically necessary. The Department may review for medical necessity at any time before or after payment. The Medicaid client is financially responsible for these services and the Department recommends the client agree in writing before the services are provided. See *When to Bill Medicaid Clients* in the *Billing Procedures* chapter of this manual.
- Medicaid does not cover services that are not direct patient care such as the following:
  - Missed or canceled appointments
  - Mileage and travel expenses for providers
  - Preparation of medical or insurance reports
  - Service charges or delinquent payment fees
  - Telephone services in home
  - Remodeling of home
  - Plumbing service
  - Car repair and/or modification of automobile

Coverage of Specific Services

The following are coverage rules for specific RHC and FQHC services.

Visiting Nurses

Part-time or intermittent nursing care and related medical services other than drugs and biologicals may be provided to a homebound (see definition below) individual by a clinic:

- Only in geographic areas designated by the Secretary of the United States Department of Health and Human Services as having a shortage of home health agencies and services;

- **When services are rendered to a homebound patient only. A homebound individual is a person who is permanently or temporarily confined to his or her place of residence because of a medical or health condition. For this purpose, place of residence does not include a hospital or long term care facility.**
- When a registered nurse, licensed practical nurse, or licensed vocational nurse that is employed or compensated by the clinic furnishes services.
- Under a written plan of treatment which is either:
  - Established and periodically reviewed (at least every 60 days) by a physician; or
  - Established by a nurse practitioner or physician assistant and periodically reviewed and approved by a supervising physician (at least every 60 days).

Laboratory services

Clinics must send a copy of their Clinical Laboratory Improvement Act (CLIA) registration number to ACS. These numbers are assigned by CMS. See *Key Contacts* for further information.

Other Programs

This is how the information in this chapter applies to Department programs other than Medicaid.

Mental Health Services Plan (MHSP)

MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Children's Health Insurance Plan (CHIP)

The information in this chapter does not apply to CHIP clients. RHC and FQHC services for children with CHIP coverage are covered by the BlueCHIP plan of BlueCross BlueShield of Montana (BCBSMT). For more information contact BCBSMT at (800) 447-7828 x8647 or (406) 447-8647. Additional information regarding CHIP is available on the *CHIP* website (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

PASSPORT and Prior Authorization

What Is PASSPORT, Team Care and Prior Authorization? (ARM 37.85.205 and 37.86.5101 - 5120)

PASSPORT To Health, the Team Care Program and prior authorization (PA) are examples of the Department's efforts to ensure the appropriate use of Medicaid services. In each case, providers need approval before services are provided to a particular client. PASSPORT approval and prior authorization are different, and some services may require both. A different code is issued for each type of approval and must be included on the claim form (see the *Completing A Claim* chapter in this manual).

- ***PASSPORT To Health Managed Care Program*** is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider. Most Montana Medicaid clients must participate in PASSPORT with only a few exceptions. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits elsewhere in the Medicaid Program. For more information on PASSPORT To Health, see the *General Information For Providers* manual, *PASSPORT and Prior Authorization* chapter.
- ***Team Care*** is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT primary care provider (PCP) and a single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system. Team care is a component of the PASSPORT program, and all PASSPORT rules and guidelines apply to these clients. For more information on the Team Care Program and Nurse First, see the *General Information For Providers* manual or the *Team Care* page on the Provider Information website (see *Key Contacts*).
- ***Prior authorization*** refers to a list of services. If a service requires prior authorization, the requirement exists for all Medicaid clients. When prior authorization is granted, the provider is issued a PA number which must be on the claim. See *Prior Authorization* later in this chapter for instructions on how to obtain prior authorization for covered services.

Different codes are issued for PASSPORT approval and prior authorization, and both must be recorded on the UB-92 claim form.

Medicaid does not pay for services when prior authorization or PASSPORT requirements are not met.

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Specific services may also require prior authorization regardless of whether the client is a PASSPORT enrollee. Refer to *Prior Authorization* later in this chapter and the fee schedules for PA requirements. PASSPORT approval requirements are described below.

PASSPORT Information for All Providers

Client eligibility verification will indicate whether the client is enrolled in PASSPORT. The client's PASSPORT provider and phone number are also available, and the client may have full or basic coverage. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual and in the *Covered Services* chapter of this manual. Prior authorization and Team Care requirements must also be followed.

PASSPORT Referral and Approval (ARM 37.86.5110)

PASSPORT referral and approval is needed for most medically necessary services that the client's PASSPORT provider does not provide. Referrals can be made to any other provider who accepts Montana Medicaid. Referrals can be verbal or in writing, and must be accompanied by the PASSPORT provider's PASSPORT approval number. PASSPORT providers are required to document PASSPORT referrals in the client's records or in a telephone log book. The PASSPORT provider establishes the parameters of referrals, which may be for a one-time visit, a time specific period, or the duration of an illness or pregnancy. An optional referral form is available in this chapter and on the Provider Information website (see *Key Contacts*).

It is best to get PASSPORT approval in advance, in writing, and specific to service(s) and date(s). If a provider accepts a client as a Medicaid client and provides a service (that requires PASSPORT provider approval) without the client's PASSPORT provider's approval, Medicaid will deny the claim. If a provider tries unsuccessfully to get approval from the PCP, the provider cannot bill the client. The provider can bill the client if the client agreed to pay privately before services were rendered (ARM 37.85.406). For details on when providers can bill Medicaid clients, see the *Billing Procedures* chapter in the Medicaid billing manual for your provider type.

PASSPORT approval and prior authorization are different, and both may be required for a service. See the *Additional Medicaid Requirements for PASSPORT Clients* chapter in this manual, and the Medicaid billing manual for your specific provider type for more information on prior authorization and PASS-

PORT. The *Medicaid Covered Service*s table in *Appendix A* of the *General Information For Providers* manual is an overview of services with prior authorization and PASSPORT indicators.

PASSPORT and Emergency Services

PASSPORT providers must provide **direction** to clients in need of emergency care 24 hours each day, seven days a week. For more information on direction, education, and suitable coverage for emergency care, see the *Role of the PASSPORT Provider* chapter in this manual.

- **Emergency services provided in the emergency department.** PASSPORT provider approval is not required for emergency services. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Non-emergencies in the ED will not be reimbursed, except for the screening and evaluation fee and any appropriate imaging and diagnostic services that are part of the screening. For more information, see *Emergency Services* on the Provider Information website or in the Medicaid billing manual for your provider type (see *Key Contacts*).
- **Post stabilization and PASSPORT.** If inpatient hospitalization is recommended as post stabilization treatment, the hospital must get a referral from the client's PASSPORT provider. If the hospital attempts to contact the PASSPORT provider and does not receive a response within 60 minutes, authorization is assumed. To be paid for these services, documentation must be sent to the PASSPORT program officer (see *Key Contacts*) for review. The documentation must include the time an attempt was made to reach the provider and the time the inpatient hospitalization began. There must be a 60 minute time lapse between these two events.

Complaints and grievances

Providers may call Provider Relations (see *Key Contacts*) to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the PASSPORT Program Officer (see *Key Contacts*).

PASSPORT and Indian Health Services

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose IHS or another provider as their PASSPORT provider. Clients who are eligible for IHS do not need a referral from their PASSPORT provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the PASSPORT provider must approve the referral.

Getting questions answered

The *Key Contacts* list (at the front of this manual) provides important phone numbers and addresses. Provider and Client HelpLines are available to answer almost any PASSPORT or general Medicaid question. You may call the PASSPORT Provider HelpLine to obtain materials for display in your office, discuss

any problems or questions regarding your PASSPORT clients, or enroll in PASSPORT. You can keep up with changes and updates to the PASSPORT program by reading the PASSPORT provider newsletters. Newsletters and other information is available on the *Provider Information* web site (see *Key Contacts*). For claims questions, call Provider Relations.

When Your Client Is Enrolled in PASSPORT (and You Are Not the PASSPORT Provider)

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of the *General Information For Providers* manual, and in the *Covered Services* chapter of this manual. Prior authorization and Team Care requirements must also be followed.

- FQHCs and RHCs require approval from a client's primary care provider if the FQHC or RHC is not the client's PASSPORT provider and the services require PASSPORT authorization.
- If a client is enrolled in PASSPORT, the services must be provided or approved by the client's PASSPORT provider. Some exceptions to this requirement are described in the *PASSPORT referral and approval* section earlier in this chapter.
- The PASSPORT provider's approval may be verbal or written but must be documented and maintained in the client's file, and the claim must contain the PASSPORT provider's PASSPORT number. Documentation should not be submitted with the claim.
- The client's PASSPORT provider must be contacted for approval for each visit. Using another provider's PASSPORT number without approval is considered fraud.
- If a PASSPORT provider refers a client to you, do not refer that client to someone else without the PASSPORT provider's approval, or Medicaid will not cover the service.
- To verify client eligibility, see the *Client Eligibility* chapter in the *General Information For Providers* manual.

Role of the PASSPORT Provider

PASSPORT providers manage a client's health care in several ways:

- Provide primary care, including preventive care, health maintenance, and treatment of illness and injury.
- Coordinate the client's access to medically necessary specialty care and other health services. Coordination includes referral, authorization, and follow-up.
- Authorize inpatient admissions.

- Provide or arrange for qualified medical personnel to be accessible 24 hours a day, 7 days a week to provide direction to clients in need of emergency care.
- Provide or arrange for suitable coverage for needed services, consultations, and approval of referrals during the provider's normal hours of operation.
- Provide or arrange for Well Child Check Ups and immunizations according to the periodicity schedule in the *Well Child EPSDT* chapter and *Appendix B* of this manual.
- Maintain a unified medical record for each PASSPORT client. This must include a record of all approvals for other providers. Providers must transfer a copy of the client's medical record to a new primary care provider if requested in writing by the client.
- Review PASSPORT utilization rates (supplied by Medicaid) and analyze factors contributing to unusually high or low rates.

Providing PASSPORT referral and authorization

- Before referring a PASSPORT client to another provider, verify that the provider accepts Medicaid.
- When referring a client to another provider, you must give that provider your PASSPORT number.
- All referrals must be documented in the client's medical record or a telephone log. Documentation should not be submitted with the claim.
- PASSPORT approval may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy, as determined by the PASSPORT provider.

Client disenrollment

A provider can ask to disenroll a PASSPORT client for any reason including:

- The provider-client relationship is mutually unacceptable.
- The client fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- The client is abusive.
- The client could be better treated by a different type of provider, and a referral process is not feasible.

Providers cannot terminate a provider-client relationship in mid-treatment. To disenroll a client, write to PASSPORT To Health (see *Key Contacts*). Providers must continue to provide PASSPORT management services to the client while the disenrollment process is being completed.

Termination of PASSPORT agreement

To terminate your PASSPORT agreement, notify PASSPORT To Health in writing at least 30 days before the date of termination. Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30 day time period to elapse.

Utilization review

PASSPORT providers' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns.

Caseload limits

PASSPORT providers may serve as few as one or as many as 1,000 Medicaid clients. Group practices and clinics may serve up to 1,000 clients for each full-time equivalent provider.

Becoming a PASSPORT Provider (ARM 37.86.5112)

A primary care provider (PCP) can be a physician or a mid-level practitioner, other than a certified registered nurse anesthetist, who is responsible for providing primary care case management by agreement with the Department. The Department allows any provider who has primary care within his or her professional scope of practice to be a PCP. The Department does, however, recognize that certain specialties are more likely to practice primary care. The Department actively recruits these providers.

PASSPORT Provider Enrollment

To enroll in PASSPORT, Medicaid providers must complete a PASSPORT provider agreement. The PASSPORT provider agreement and the *PASSPORT To Health Provider Handbook* are available on the Provider Information website (see *Key Contacts*). Providers may also call Provider Relations (see *Key Contacts*) for information on becoming a PASSPORT provider and to get the PASSPORT provider agreement.

Group PASSPORT provider

A Group PASSPORT provider is enrolled in the program as having one or more Medicaid providers practicing under one PASSPORT number. The Group name will be listed as the client's PASSPORT provider and could be a private group clinic, Rural Health Clinic, Federally Qualified Health Center, or Indian Health Services (IHS). All participating providers sign the PASSPORT agreement group signature page and are responsible for managing the caseload. As a Group provider, clients may visit any provider within the group practice without PASSPORT approval. For details on referral documentation,

see *PASSPORT Referral and Approval* in the *PASSPORT Referral* chapter of this manual. Case management fees are paid as a group under the group's PASSPORT number separate from the fee-for-service reimbursement.

PASSPORT Tips

- View the client's Medicaid eligibility verification at each visit using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's PASSPORT provider, include the PASSPORT provider's PASSPORT approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to PASSPORT and non-PASSPORT clients and services.
  For claims questions, refer to the *Billing Procedures* chapter in this manual, or call Provider Relations (see *Key Contacts*).

Prior Authorization

RHC and FQHC services do not require prior authorization (PA) unless the diagnosis code requires it. If you are making a referral, remember that some services require prior authorization (PA) before they are provided. When seeking PA, keep in mind the following:

- The referring provider should initiate all authorization requests.
- Always refer to the current Medicaid fee schedule to verify if PA is required for specific services.
- The following table (*PA Criteria for Specific Services*) lists services that require PA, who to contact, and specific documentation requirements.
- Have all required documentation included in the packet before submitting a request for PA (see the following *PA Criteria for Specific Services* table for documentation requirements).
- When PA is granted, providers will receive notification containing a PA number. This PA number must be included in form locator 63 on the UB-92 claim form.
- Providers must comply with all requirements for Medicaid prior authorization before providing services or before payment, as applicable to the particular category of services being provided.

PA Criteria for Specific Services

Service	PA Contact	Documentation Requirements

• **All transplant services**
• **Out-of-state hospital inpatient services**
• **All rehab services**
• **Therapy services over limit for children**
	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In and out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In and out of state
		• Required information includes:
		  • Client's name
		  • Client's Medicaid ID number
		  • State and hospital where client is going
		  • Documentation that supports medical necessity. This varies based on circumstances. Mountain-Pacific Quality Health Foundation will instruct providers on required documentation on a case-by-case basis.

• **Emergency department reviews**	Mountain-Pacific Quality Health Foundation
	3404 Cooney Drive
	Helena, MT 59602
	
	Phone:
	(406) 443-4020 X5850 Helena
	(800) 262-1545 X5850 In and out-of-state
	Fax:
	(406) 443-4585 Helena
	(800) 497-8235 In and out of state
		• Required information includes:
		  • A copy of the claim
		  • A copy of the emergency department report

• **Transportation (scheduled ambulance transport, commercial and specialized non-emergency transportation)**
 	
(For emergency ambulance transport services, providers have 60 days following the service to obtain authorization (see the *Ambulance* manaul .)
	Mountain-Pacific Quality Health Foundation
	Medicaid Transportation
	P.O. Box 6488
	Helena, MT 59604
	
	Phone:
	(800) 292-7114
	Fax:
	(800) 291-7791
	E-Mail:
	ambulance@mpqhf.org
		• Ambulance providers may call, leave a message, fax, or E-mail requests.
		• Required information includes:
		  • Name of transportation provider
		  • Provider's Medicaid ID Number
		  • Client's name
		  • Client's Medicaid ID number
		  • Point of origin to the point of destination
		  • Date and time of transport
		  • Reason for transport
		  • Level of services to be provided during transport (e.g., BLS, ALS, mileage, oxygen, etc.)
		• Providers must submit the trip report and copy of the charges for review after transport.
		• For commercial or private vehicle transportation, clients call and leave a message, or fax travel requests prior to traveling.

• **Dispensing and fitting of contact lenses**	Provider Relations
	P.O. Box 4936
	Helena, MT 59604
	
	Phone:
	(406) 442-1837 Helena and out of state
	(800) 624-3958 In state
		• PA required for contact lenses and dispensing fees.
		• Diagnosis must be one of the following:
		  • Keratoconus
		  • Aphakia
		  • Sight cannot be corrected to 20/40 with eyeglasses

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• **Eye prosthesis** • **New technology codes (Category III CPT codes)** • **Other reviews referred by Medicaid program staff**	Surveillance/Utilization Review Section P.O. Box 202953 Helena, MT 59620-2953 **Phone:** (406) 444-6977 **Fax:** (406) 444-0778	• Documentation that supports medical necessity • Documentation regarding the client's ability to comply with any required after care • Letters of justification from referring physician • Documentation should be provided at least two weeks prior to the procedure date.

• **Circumcision**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• Circumcision requests are reviewed case-by-case basis based on medical necessity when one of the following occurs:
		  • Client has scarring of the opening of the foreskin making it non-retractable (pathological phimosis). This is unusual before five years of age. Phimosis must be treated with non-surgical methods (i.e., topical steroids) before circumcision is indicated.
		  • Documented recurrent, troublesome episodes of infection beneath the foreskin (balanoposthitis) that does not respond to other non-invasive treatments and/or sufficient hygiene
		  • Urinary obstruction
		  • Urinary tract infections

• **Maxillofacial / cranial surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• Surgical services are only covered when done to restore physical function or to correct physical problems resulting from:
		  • Motor vehicle accidents
		  • Accidental falls
		  • Sports injuries
		  • Congenital birth defects
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Medicaid does not cover these services for the following:
		  • Improvement of appearance or self-esteem (cosmetic)
		  • Dental implants
		  • Orthodontics

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Blepharoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• Reconstructive blepharoplasty may be covered for the following:
		  • Correct visual impairment caused by drooping of the eyelids (ptosis)
		  • Repair defects caused by trauma-ablative surgery (ectropion/entropion corneal exposure)
		  • Treat periorbital sequelae of thyroid disease and nerve palsy
		  • Relieve painful symptoms of blepharospasm (uncontrollable blinking).
		• Documentation must include the following:
		  • Surgeon must document indications for surgery
		  • When visual impairment is involved, a reliable source for visual-field charting is recommended
		  • Complete eye evaluation
		  • Pre-operative photographs
		• Medicaid does not cover cosmetic blepharoplasty

• **Botox myobloc**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• For more details on botox criteria, coverage, and limitations, visit the Provider Information website (see *Key Contacts*)
		• Botox is covered for treating the following:
		Laryngeal spasm; Blepharospasm; Hemifacial spasm of the nerve; Torticollis, unspecified; Torsion dystonia; Fragments of dystonia; Hereditary spastic paraplegia; Multiple Sclerosis; Spastic hemiplegia; Infantile cerebral palsy; Other specified infantile cerebral palsy; Achalasia and cardiospasm; Spasm of muscle; Hyperhidrosis; Strabismus and other disorders of binocular eye movements; Other demyelinating diseases of the central nervous system
		• Documentation requirements include a letter from the attending physician supporting medical necessity including:
		  • Client's condition (diagnosis)
		  • A statement that traditional methods of treatments have been tried and proven unsuccessful
		  • Proposed treatment (dosage and frequency of injections)
		  • Support the clinical evidence of the injections
		  • Specify the sites injected
		• Myobloc is reviewed on a case-by-case basis

• **Excising excessive skin and subcutaneous tissue**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• Required documentation includes the following:
		  • The referring physician and surgeon must document the justification for the resection of skin and fat redundancy following massive weight loss.
		  • The duration of symptoms of at least six months and the lack of success of other therapeutic measures
		  • Pre-operative photographs
		• This procedure is contraindicated for, but not limited to, individuals with the following conditions:
		  • Severe cardiovascular disease
		  • Severe coagulation disorders
		  • Pregnancy
		• Medicaid does not cover cosmetic surgery to reshape the normal structure of the body or to enhance a client's appearance.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Rhinoplasty septorhinoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• The following do not require PA:
		  • Septoplasty to repair deviated septum and reduce nasal obstruction
		  • Surgical repair of vestibular stenosis to repair collapsed internal valves to treat nasal airway obstruction
		• Medicaid covers rhinoplasty in the following circumstances:
		  • To repair nasal deformity caused by a cleft lip/cleft palate deformity for clients 18 years of age and younger
		  • Following a trauma (e.g. a crushing injury) which displaced nasal structures and causes nasal airway obstruction.
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		• Not covered
		  • Cosmetic rhinoplasty done alone or in combination with a septoplasty
		  • Septoplasty to treat snoring

• **Temporomandibular joint (TMJ) arthroscopy/ surgery**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• Non-surgical treatment for TMJ disorders must be utilized **first** to restore comfort and improve jaw function to an acceptable level. Non-surgical treatment may include the following in any combination depending on the case:
		  • Fabrication and insertion of an intra-oral orthotic
		  • Physical therapy treatments
		  • Adjunctive medication
		  • Stress management
		• Surgical treatment may be considered when both of the following apply:
		  • Other conservative treatments have failed (must be documented), and chronic jaw pain and dysfunction have become disabling. Conservative treatments must be utilized for six months before consideration of surgery.
		  • There are specific, severe structural problems in the jaw joint. These include problems that are caused by birth defects, certain forms of internal derangement caused by misshapen discs, or degenerative joint disease. For surgical consideration, arthrogram results must be submitted for review.
		• Not covered:
		  • Botox injections for the treatment of TMJ are considered experimental.
		  • Orthodontics to alter the bite
		  • Crown and bridge work to balance the bite
		  • Bite (occlusal) adjustments

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements
• **Partial hospitalization**	First Health Services 4300 Cox Road Glen Allen, VA 23060 **Phone:** (800) 770-3084 **Fax:** (800) 639-8982 Fax (800) 247-3844 Fax	• A certificate of need must be completed, signed, and dated no more than 30 days prior to the date of admission. • The certificate must be completed by a team of health care professionals that have competence in the diagnosis and treatment of mental illness and the patient's psychiatric condition.

• **Dermabrasion / abrasion chemical peel**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• Services covered for the following:
		  • Treating severe, deep acne scarring not responsive to conservative treatment. All conservative treatments must have been attempted and documented for at least six months before medical necessity is determined.
		  • The removal of pre-cancerous skin growths (keratoses)
		• Documentation requirements include a letter from the attending physician documenting:
		  • Client's condition
		  • Proposed treatment
		  • Reason treatment is medically necessary
		  • Pre-operative photographs

• **Positron emission tomography (PET) scans**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT 59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• PET scans are covered for the following clinical conditions: (For more details on each condition and required documentation, contact the SURS unit.)
		  • Solitary pulmonary nodules (SPNs) - characterization
		  • Lung cancer (non small cell) - Diagnosis, staging, restaging
		  • Esophageal cancer - Diagnosis, staging, restaging
		  • Colorectal cancer - Diagnosis, staging, restaging
		  • Lymphoma - Diagnosis, staging, restaging
		  • Melanoma - Diagnosis, staging, restaging. Not covered for evaluating regional nodes
		  • Breast cancer - As an adjunct to standard imaging modalities for staging clients with distant metastasis or restaging clients with locoregional recurrence or metastasis; as an adjunct to standard imaging modalities for monitoring tumor response to treatment for women with locally and metastatic breast cancer when a change in therapy is anticipated
		  • Head and neck cancers (excluding central nervous system and thyroid) - Diagnosis, staging, restaging
		  • Myocardial viability - Primary or initial diagnosis, or following an inconclusive SPECT prior to revascularization. SPECT may not be used following an inconclusive PET scan.
		  • Refractory seizures - Covered for pre-surgical evaluation only.
		  • Perfusion of the heart using Rubidium 82 tracer (Not DFG-PET) - Covered for noninvasive imaging of the perfusion of the heart.

PA Criteria for Specific Services (continued)

Service	PA Contact	Documentation Requirements

• **Reduction mammoplasty**	Surveillance/Utilization Review Section
	P.O. Box 202953
	Helena, MT
	59620-2953
	
	Phone:
	(406) 444-6977
	
	Fax:
	(406) 444-0778
		• Both the referring physician and the surgeon must submit documentation.
		• Back pain must have been documented and present for at least six months, and causes other than breast weight must have been excluded.
		• **Indications for female client:**
		• Contraindicated for pregnant women and lactating mothers. A client must wait six months after the cessation of breast feeding before requesting this procedure.
		• Female client 16 years or older with a body weight less than 1.2 times the ideal weight.
		• There must be severe, documented secondary effects of large breasts, unresponsive to standard medical therapy administered over at least a six month period. This must include at least two of the following conditions:
		  • Upper back, neck, shoulder pain that has been unresponsive to at least six months of documented and supervised physical therapy and strengthening exercises
		  • Paresthesia radiating into the arms. If parathesia is present, a nerve conduction study must be submitted.
		  • Chronic intertrigo (a superficial dermatitis) unresponsive to conservative measures such as absorbent material or topical antibiotic therapy. Document extent and duration of dermatological conditions requiring antimicrobial therapy.
		  • Significant shoulder grooving unresponsive to conservative management with proper use of appropriate foundation garments which spread the tension of the support and lift function evenly over the shoulder, neck and upper back.
		Documentation in the client's record must indicate and support the following:
		• History of the client's symptoms related to large, pendulous breasts.
		• The duration of the symptoms of at least six months and the lack of success of other therapeutic measures (e.g., documented weight loss programs with six months of food and calorie intake diary, medications for back/neck pain, etc.).
		• Guidelines for the anticipated weight of breast tissue removed from each breast related to the client's height (which must be documented):
		Height — **Weight of tissue per breast**
		less than 5 feet — 250 grams
		5 feet to 5 feet, 2 inches — 350 grams
		5 feet, 2 inches to 5 feet, 4 inches — 450 grams
		greater than 5 feet, 4 inches — 500 grams
		• Pre-operative photographs of the pectoral girdle showing changes related to macromastia.
		• Medication use history. Breast enlargements may be caused by various medications (e.g., sironolactone, cimetidine) or illicit drug abuse (e.g., marijuana, heroin, steroids). Although rare in women, drug effects should be considered as causes of breast enlargement prior to surgical treatment since the problem may recur after the surgery if the drugs are continued. Increased prolactin levels can cause breast enlargement (rare). Liver disease, adrenal or pituitary tumors may also cause breast enlargement and should also be considered prior to surgery.
		• **Indications for male client:**
		• If the condition persists, a client may be considered a good candidate for surgery. Clients who are alcoholic, illicit drug abusers (e.g., steroids, heroin, marijuana) or overweight are not good candidates for the reduction procedure until they attempt to correct their medical problem first.
		• Documentation required: length of time gynecomastia has been present, height, weight, and age of the client, pre-operative photographs

Other Programs

Clients who are enrolled in the Mental Health Services Plan (MHSP) or the Children's Health Insurance Plan (CHIP) are not enrolled in PASSPORT, so the PASSPORT requirements in this chapter do not apply. However, prior authorization may be required for certain services. Refer to the *Mental Health* manual.

For more CHIP information, contact BlueCross BlueShield of Montana at (800) 447-7828 x8647. Additional CHIP information is available on the Provider Information website (see *Key Contacts*).

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, Workers' Compensation, employment-based coverage, individually purchased overage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers must bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* later in this chapter). Medicare coverage is processed differently than other sources of coverage.

Identifying Other Sources of Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see *Client Eligibility and Responsibilities* in the *General Information For Providers* manual). If a client has Medicare, the Medicare ID number is provided. If a client has other coverage (excluding Medicare), it will be shown under the "TPL" section. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' Compensation insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

* These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers must use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

For RHCs, Medicare claims are processed and paid differently than claims involving other payers. The other sources of coverage are referred to as "third party liability" (TPL), but Medicare is not. For FQHCs, Medicare payments are handled as TPL payments.

Medicare claims

Medicare covers RHC and FQHC covered services. Providers must submit the claim first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB, and submits the claim to Medicaid.

For details on how Medicaid calculates payment for Medicare claims, see the *How Payment Is Calculated* chapter in this manual.

When Medicare pays or denies a service

When RHC or FQHC claims for clients with Medicare and Medicaid:

- Are paid, submit the claim to Medicaid on a UB-92 form with the Medicare coinsurance and deductible information in the "Value Codes" form locators (39-41) and Medicare paid amounts in the "Prior Payments" form locator (54). See the *Billing Procedures* and *Completing a Claim* chapters in this manual.
- Are allowed, and the allowed amount went toward client's deductible, include the deductible information in the "Value Codes" form locators (39-41) and submit the claim to Medicaid.
- Are denied, the provider submits a paper claim to Medicaid with the Medicare EOMB and the explanation of denial codes attached. If Medicare denies a claim because the service was not medically necessary, Medicaid will also deny the claim.

Medicare Part A crossover claims do not automatically cross over from Medicare.

Submitting Medicare claims to Medicaid

When submitting a paper claim to Medicaid, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must include the Medicaid provider number and Medicaid client ID number. The Medicare EOMB and explanation of denial codes are required only if the claim was denied.

When billing Medicaid for a client with coverage from multiple sources, see the *Billing Procedures* chapter in this manual.

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability (or TPL). In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers equal to what Medicaid paid (when the services were billed to Medicaid) must be turned over to the Department. Amounts in excess of what Medicaid paid must be returned to the provider. The following words printed on the client's statement will fulfill this requirement: "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to billing third party first

In a few cases, providers may bill Medicaid first.

- When a Medicaid client is also covered by Indian Health Service (IHS) or the Montana Crime Victim's Compensation Fund, providers must bill Medicaid before IHS or Crime Victim's. These are not considered third party liability.
- When a client has Medicaid eligibility and Mental Health Services Plan (MHSP) eligibility for the same month, Medicaid must be billed before MHSP.
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim form. Instead, notify the Department of the potential third party by sending the claim and notification to the Department Third Party Liability Unit:

  Third Party Liability Unit
  Department of Public Health & Human Services
  P.O. Box 202953
  Helena, MT 59620-2953

Requesting an exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information must be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- If another insurance has been billed, and 90 days have passed with no response, attach a note to the claim explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation directly to Medicaid in order to avoid missing the timely filing deadline.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  1. The third party carrier has been billed, and 30 days or more have passed since the date of service.
  2. The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

When the third party pays or denies a service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid in the "prior payments" form locator of the claim when submitting to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Reason and Remarks (formerly EOB) when billing Medicaid. With HIPAA implementation, these claims may be submitted on paper or electronically with the paper attachment mailed in separately. A paper attachment cover sheet is available on the Provider Information website (see *Key Contacts*). Until HIPAA implementation, continue to bill on paper with attachments.
- Denies the claim, include a copy of the denial (including the denial reason codes) with the claim form, and submit to Medicaid on paper.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the third party does not respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Attach to the paper claim a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

For details on how Medicaid calculates payment for TPL claims, see the *How Payment Is Calculated* chapter in this manual.

Other Programs

MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*). The information in this chapter does not apply to clients enrolled in the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Billing Procedures

Claim Forms

RHC and FQHC services must be billed either electronically or on a UB-92 claim form. UB-92 forms are available from various publishing companies; they are not available from the Department or Provider Relations.

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- Twelve months from whichever is later:
    - the date of service
    - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
    - ***Medicare crossover claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
    - ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or action from the provider. The submission date is defined as the date that the claim was received by the Department or the claims processing contractor. All problems with claims must be resolved within this 12-month period.

Tips to avoid timely filing denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status (see *Key Contacts*).

- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

When To Bill Medicaid Clients (ARM 37.85.406)

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

In most circumstances, providers may not bill Medicaid clients for services covered under Medicaid. The main exception is that providers may collect cost sharing from clients.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a Medicaid client by the provider, even if the claim was denied.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment. Medicaid may not be billed for no-show appointments.
- When services are free to the client, such as in a public health clinic. Medicaid may not be billed for those services.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

When to Bill a Medicaid Client (ARM 37.85.406)

	• Client Is Medicaid Enrolled • Provider Accepts Client as a Medicaid Client	• Client Is Medicaid Enrolled • Provider Does Not Accept Client as a Medicaid Client	• Client Is Not Medicaid Enrolled
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and that he or she must pay for the services received.

Custom Agreement: This agreement lists the service and date the client is receiving the service and states that the service is not covered by Medicaid and that the client will pay for it.

Client cost sharing for RHC and FQHC services is $5.00 per visit.

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap. Do not show cost sharing as a credit on the claim; it is automatically deducted during claims processing and is shown on the remittance advice. Cost sharing for RHC and FQHC services is $5.00 per visit.

Do not show cost sharing as a credit on the claim; it is automatically deducted.

The following clients are exempt from cost sharing:

- Clients under 21 years of age (i.e., EPSDT services)
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing if the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

Cost sharing may not be charged for the following services:

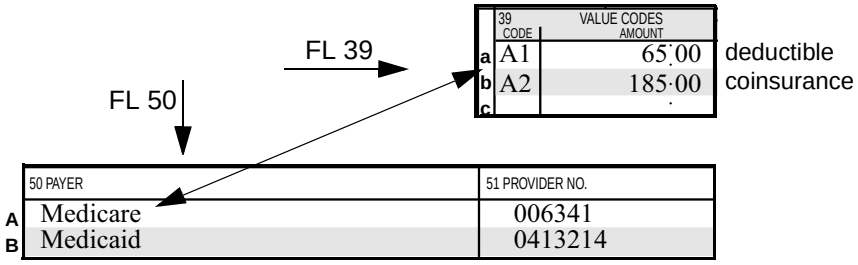
- Emergencies (see *Definitions*)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home and community based waiver services
- Non-emergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services

A provider cannot deny services to a Medicaid client because the client cannot pay cost sharing fees at the time services are rendered. However, the client's inability to pay cost sharing fees when services are rendered does not lessen the client's obligation. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients.

Billing for Clients With Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see the *Coordination of Benefits* chapter in this manual.

When completing a claim for clients with Medicare and Medicaid, Medicare coinsurance and deductible amounts listed in FL 39 must correspond with the payer listed in FL 50. For example, if the client has Medicare and Medicaid, any Medicare deductible and coinsurance amounts should be listed in FL 39 preceded by an A1, A2, etc. Because these amounts are for Medicare, Medicare should be listed in FL 50A (see the *Completing a Claim* chapter in this manual).



Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the RHC/FQHC provider may:

- Accept the client as a Medicaid client from the current date.
- Accept the client as a Medicaid client from the date retroactive eligibility was effective.
- Require the client to continue as a private-pay client.

When the provider accepts the client's retroactive eligibility, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, attach a copy of the FA-455 (eligibility determination letter) to the claim if the date of service is more than 12 months earlier than the date the claim is submitted. Providers may need to contact the client's local office of public assistance (see the *General Information For Providers* manual, *Appendix B: Local Offices of Public Assistance*).

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

Coding

Standard use of medical coding conventions is required when billing Medicaid. Provider Relations or the Department cannot suggest specific codes to be used in billing for services. For coding assistance and resources, see the table of *Coding Resources* on the following page. The following suggestions may help reduce coding errors and unnecessary claim denials:

Always refer to the long descriptions in coding books.

- Use current CPT-4, HCPCS Level II, and ICD-9-CM coding books.
- Always read the complete description and guidelines in the coding books. Relying on short descriptions can result in inappropriate billing.
- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than unlisted codes. For example, don't use 53899 unlisted procedure of the urinary system when a more specific code is available.
- Bill for the appropriate level of service provided. Evaluation and management services have three to five levels. See your CPT manual for instructions on determining appropriate levels of service.
- CPT codes that are billed based on the amount of time spent with the client must be billed with the code that is closest to the time spent. For example, a provider spends 60 minutes with the client. The code choices are 45 to 50 minutes or 76 to 80 minutes. The provider must bill the code for 45 to 50 minutes.
- Take care to use the correct "units" measurement. In general, Medicaid follows the definitions in the CPT-4 and HCPCS Level II billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be "each 15 minutes." Always check the long text of the code description published in the CPT-4 or HCPCS Level II coding books.
- RHCs and FQHCs must use the following revenue codes as specified by the Department. Check with Provider Relations (see *Key Contacts*) to make sure they are valid for your facility. Use of these revenue codes (if invalid for your clinic) will result in nonpayment.

  B 512 Dental
  R 521 RHC Core Services
  B 522 Visiting Nurse
  F 529 FQHC Core Services

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm
UB-92 National Uniform Billing Data Element Specifications	Montana UB-92 billing instructions	MHA - An Association of Montana Health Care Providers (formerly Montana Hospital Assoc.) Box 5119 Helena, MT 59604 406-442-1911 phone 406-443-3984 fax

Number of Lines on Claim

Clinic claims are reimbursed using an all-inclusive rate of payment per visit. Only one line per claim will receive payment.

Multiple Services on Same Date (ARM 37.86.4402)

A clinic visit is defined as a face-to-face encounter between a clinic patient and a clinic health care professional for the purpose of providing clinic core or other ambulatory services or billable incident-to services. Encounters with more than one clinic health care professional, and multiple encounters with the same clinic health care professional, on the same day at a single location constitute a single visit except when one of the following exists:

- After the first encounter, the patient suffers an additional illness or injury requiring additional diagnosis or treatment, or
- The patient has a medical visit and a mental health visit, or a medical visit and a dental visit, or a mental health visit and a dental visit.

See *Key Contacts* for mailing claims for multiple visits on the same day. The second claim must be mailed directly to the RHC and FQHC program officer or it will be denied due to duplicate services.

Span Bills

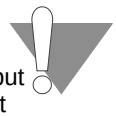
Span billing is not allowed for RHCs and FQHCs. Providers may bill for only one date of service per claim. Spans greater than one date of service in form locater (FL) 6 will result in payment for one date of service. Reimbursement of other dates of service within the span is not possible until the paid claim is adjusted to reflect one date of service only.

Reporting Service Dates

- All line items must have a valid date of service in form locator (FL) 45.
- All clinic revenue codes require a valid CPT or HCPCS Level II code in form locator (FL) 44 that is appropriate for clinics.

Using Modifiers

- Review the guidelines for using modifiers in the most current CPT-4 book, HCPCS Level II book, and other helpful resources (e.g., CPT Assistant, APC Answer Letter and others).
- Always read the complete description for each modifier; some modifiers are described in the CPT-4 manual while others are in the HCPCS Level II book.
- Medicaid accepts the same modifiers as Medicare.
- The Medicaid claims processing system recognizes only one modifier. The modifier must be added to the CPT/HCPCS code without a space or



Clinics should put the most important modifiers in the first position.

hyphen in form locator (FL) 44. For example, 25680 (treatment of wrist fracture) when done bilaterally is reported as 2568050.

- Since the Medicaid claims processing system can read only one modifier per line, it is important to report the most important modifier first.

Service Settings

Clinic services are covered when provided in an outpatient setting including the clinic, other medical facility (including a dental office) or a patient's place of residence. A patient's place of residence may be a nursing facility or other institution used as the patient's home. Clinic services are covered off-site as long as the service is normally furnished within the scope of the clinic's professional services. Services provided off-site are part of the clinic benefit if the provider has an agreement with the clinic that Medicaid payment will be made to the clinic for those services. If the clinic doesn't compensate the provider for services provided off-site, the clinic may not bill Medicaid for those services.

FQHCs must not bill in the hospital setting. RHCs may bill in the hospital setting but not for inpatient surgeries and deliveries.

FQHC providers that perform services in a hospital setting must bill the service on a CMS-1500 using their own provider number. RHC providers who perform inpatient surgeries or deliveries must unbundle the service and bill for the surgery (using modifier 54) or delivery only (procedure codes 59409 or 59514) on a CMS-1500 using their own provider number.

Pre- and post-visits at the clinic are billed by the clinic on a UB-92 as a core service.

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims must be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

Electronic claims

Providers who submit claims electronically experience fewer errors and quicker payment. Claims may be submitted electronically by the following methods:

- ACS field software WINASAP 2003. ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers.

This software creates an 837 transaction, but does not accept an 835 transaction back from the Department.

- ACS clearinghouse. Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12 837 format using a dial-up connection. Electronic submitters are required to certify their 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- Clearinghouse. Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway

For more information on electronic claims submission, contact Provider Relations or the EDI Technical Help Desk (see *Key Contacts*).

Claim Inquiries

Contact Provider Relations for questions regarding payments, denials, general claim questions, client eligibiligy, or to request billing instructions, manuals, or fee schedules (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address. If you are including a copy of the claim, complete side A; if a copy of the claim is not included, complete side B.

Provider Relations will respond to the inquiry within seven to 10 days. The response will include the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many other claims (both paper and electronic) are denied. To avoid unnecessary returns and denials, double check each claim to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
Medicaid provider number missing or invalid	The provider number is a **7-digit** number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim.
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, hand-written, or computer generated.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	The claim must be the correct form for the provider type. Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client, verify client eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of the *General Information For Providers* manual. Medicaid eligibility may change monthly.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. PASSPORT approval is different from prior authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization number is missing	Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Prior authorization is different from PASSPORT authorization. See the *PASSPORT and Prior Authorization* chapter in this manual.
Prior authorization does not match current information	Claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization.
Duplicate claim	• When sending claims for multiple visits on the same day, the second claim must be mailed directly to the RHC and FQHC program officer. • Please check all remittance advices (RAs) for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments* in this manual).

Common Billing Errors (continued)

Reasons for Return or Denial	How to Prevent Returned or Denied Claims
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits* in this manual. • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in this chapter. • To ensure timely processing, claims and adjustments must be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All denied Medicare crossover claims must have an Explanation of Medicare Benefits (EOMB) with denial reason codes attached, and be billed to Medicaid on paper.
Provider is not eligible during dates of services, enrollment has lapsed due to licensing requirements, or provider number terminated	• Out-of-state providers must update licensure for Medicaid enrollment early to avoid denials. If enrollment has lapsed due to expired licensure, claims submitted with a date of service after the expiration date will be denied until the provider updates his or her enrollment. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider is terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Procedure is not allowed for provider type	• Provider is not allowed to perform the service. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the appropriate Medicaid fee schedule to verify the procedure code is valid for your provider type.

Other Programs

MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*). These billing procedures do not apply to the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Completing a Claim Form

The services described in this manual are billed on UB-92 claim forms. Please use this chapter with the *Montana UB-92 Reference Manual*. For more information on submitting HIPAA compliant 837 transactions, refer to the *Companion Guides* on the ACS EDI Gateway website (see *Key Contacts*). Claims submitted with all of the necessary information are referred to as "clean" and are usually paid in a timely manner (see the *Billing Procedure*s chapter in this manual).

Claims are completed differently for the different types of coverage a client has. This chapter includes instructions and a sample claim for each of the following scenarios:

- Client has Medicaid coverage only
- Client has Medicaid and Medicare coverage
- Client has Medicaid and third party liability coverage

When completing a claim, remember the following:

- Please use this information together with the UB-92 Reference Manual.
- All form locators shown in this chapter are required or situational. Situational form locators are required if the information is applicable to the situation or client and are indicated by "*".
- Form locator 11 is used for PASSPORT and FL 78 is used for cost sharing indicators (see following table and instructions in this chapter).

PASSPORT and Cost Sharing Indicators

PASSPORT To Health Indicators	
Code	**Description**
FPS	This indicator is used when providing family planning services.
OBS	This indicator is used when providing obstetrical services.
TCM	This indicator is used when providing targeted case management services.
Cost Sharing Indicators	
E	This indicator is used when providing emergency services.
F	This indicator is used when providing family planning services.
P	This indicator is used when providing services to pregnant women.

- Unless otherwise stated, all paper claims must be mailed to the following address:

Claims Processing Unit
P.O. Box 8000
Helena, MT 59604

Client Has Medicaid Coverage Only

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4	Type of bill	Enter the code indicating the type of bill (711 for RHCs, 791 for FQHCs)
6	Statement covers period	The beginning and ending service date of the period included on this bill
11*	PASSPORT To Health	Enter PASSPORT authorization number or indicator (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth
15	Patient sex	Use M (male), F (female), or U (unknown)
17-20	Admission	The admission date, hour, type, and source (see the UB-92 Reference Manual for specific codes)
22	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
42	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44	HCPCS Rates	Enter the CPT/HCPCS code for the service
45	Service date	The date the indicated service was provided
46	Service units	A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	Enter "Medicaid" when the client has Medicaid only coverage
51	Provider number	Enter the provider's Medicaid ID number
54*	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60	Cert - SSN - HIC - ID #	Client's Medicaid ID number
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers and some in-state services.
67-75	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68-75
76	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing indicator (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
82	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill

* Required if applicable

Client Has Medicaid Coverage Only

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1

Better Provider
33 Best Road
Fitness, MT 59003

2

3 PATIENT CONTROL NO. 343397

4 TYPE OF BILL 711

5 FED. TAX NO.

6 STATEMENT COVERS PERIOD FROM 02/01/06 THROUGH 02/01/06

7 COV D. | 8 N-C D. | 9 C-I D. | 10 L-R D.

11 9989887

12 PATIENT NAME: Sunshine, Bright R.

13 PATIENT ADDRESS: 493 Lighthouse Way Fitness, MT 59003

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24 25 26 27 28 29 30	31
10/12/82	F		02/01/06	07		2		01			

	32 CODE / OCCURRENCE DATE	33 CODE / OCCURRENCE DATE	34 CODE / OCCURRENCE DATE	35 CODE / OCCURRENCE DATE	36 CODE / OCCURRENCE SPAN FROM THROUGH	37
a						A
b						B
						C

38

	39 CODE / VALUE CODES AMOUNT	40 CODE / VALUE CODES AMOUNT	41 CODE / VALUE CODES AMOUNT
a			
b			
c			
d			

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	521	Office/Outpatient Visit/est.	99213	02/01/06	1	68.90		
2								
3								
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22								
23						68.90		

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A	Medicaid	0413214					
B							
C							

57 **DUE FROM PATIENT ▶**

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A	Sunshine, Bright R.		123784560		
B					
C					

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A				
B				
C				

67 PRIN. DIAG. CD.	68 CODE	OTHER DIAG. CODES 69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
789	V22.2								789		

79 P.C.	80 PRINCIPAL PROCEDURE CODE / DATE	81 OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
		A	B

OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE	OTHER PROCEDURE CODE / DATE
C	D	E

82 ATTENDING PHYS. ID: 0003421 Dr. Smiling

83 OTHER PHYS. ID A

OTHER PHYS. ID B

	84 REMARKS
a	
b	
c	
d	

85 PROVIDER REPRESENTATIVE X Betty Billing Agent

86 DATE 02/15/06

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Client Has Medicaid and Medicare Coverage

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4	Type of bill	Enter the code indicating the type of bill (711 for RHCs, 791 for FQHCs)
6	Statement covers period	The beginning and ending service date of the period included on this bill
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth
15	Patient sex	Enter M (male), F (female), or U (unknown)
17-20	Admission	The admission date, hour, type, and source (see to the UB-92 Reference Manual for specific codes)
22	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	Enter value codes A1, A2, A3, B1, B2, B3, etc followed by the deductible and coinsurance amounts. These entries must corresponds with the entries in form locator 50 (A and B). See the *Billing Procedures* chapter, *Billing with multiple payers* section in this manual.
42	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44	HCPCS Rates	Enter the CPT/HCPCS code for the service
45	Service date	The date the indicated service was provided
46	Service units	A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. Medicare should be listed first followed by Medicaid. See the *Billing Procedures* chapter, *Billing with multiple payers* section in this manual.
51	Provider number	Enter the provider's Medicare and Medicaid ID numbers
54	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60	Cert - SSN - HIC - ID #	Client's Medicaid ID number
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers and some in-state services.
67-75	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68-75
76	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing indicator code (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
82	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill

* Required if applicable

Client Has Medicaid and Medicare Coverage

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1	2	3 PATIENT CONTROL NO.	4 TYPE OF BILL
Better Provider 33 Best Road Fitness, MT 59003		45604	791

5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM	THROUGH	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11
	02/01/06	02/01/06					

12 PATIENT NAME	13 PATIENT ADDRESS
Leaves, Autumn T.	45 Maple Lane Trees, MT 59400

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
05/28/67	F		02/01/06	10		1		01									

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38

	39 CODE	39 VALUE CODES AMOUNT	40 CODE	40 VALUE CODES AMOUNT	41 CODE	41 VALUE CODES AMOUNT
a	A1	11.00				
b						
c						
d						

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
1	529	Office/Outpatient Visit, est.	99212	02/01/06	1	55.00		
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
19								
20								
21								
22								
23						55.00		

The payers in FL 50 must correspond with the payment(s) in FL 39.

50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56
A Medicare	006341			75.58		
B Medicaid	0413214					
C						
57	DUE FROM PATIENT ▶					

58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.
A Leaves, Autumn T.		134637825		
B				
C				

63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION
A			
B			
C			

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68	69	70	71	72	73	74	75	76 ADM. DIAG. CD.	77 E-CODE	78
692.9									692.9		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
			A		B	
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE
	C		D		E	

82 ATTENDING PHYS. ID	
0006240	Dr. Patients

83 OTHER PHYS. ID	
A	a
	b
OTHER PHYS. ID	a
B	b

a	84 REMARKS
b	
c	
d	

85 PROVIDER REPRESENTATIVE	86 DATE
X Nina Numbers	02/15/06

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

Client Has Medicaid and Third Party Liability Coverage

FL	Form Locator Title	Instructions
1-2	Unlabeled fields	Provider name, complete mailing address, and phone number
3	Patient control number	The client's unique alphanumeric number assigned by the provider
4	Type of bill	Enter the code indicating the type of bill (711 for RHCs, 791 for FQHCs)
6	Statement covers period	The beginning and ending service date of the period included on this bill
11*	PASSPORT To Health	Enter PASSPORT authorization number or indicator code (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
12	Patient name	Enter the Medicaid client's last name, first name and middle initial
13	Patient address	The client's mailing address including street name/P.O. box, city, state, and zip code
14	Patient birth date	The client's month, day, and year of birth
15	Patient sex	Enter M (male), F (female), or U (unknown)
17-20	Admission	The admission date, hour, type, and source (see to the UB-92 Reference Manual for specific codes)
22	Patient status	A code indicating client status as of the ending service date of the period covered on this bill (see the UB-92 Reference Manual for specific codes)
39-41*	Value codes and amounts	Enter value codes A1, A2, A3, B1, B2, B3, etc. followed by the deductible and coinsurance amounts. These entries must correspond with the entries in form locator 50 (A, B). See the *Billing Procedures* chapter, *Billing with multiple payers* section in this manual.
42	Revenue code	A code which identifies a specific accommodation, ancillary service or billing calculation (see the UB-92 Reference Manual for specific codes)
43	Description	Revenue code description (may abbreviate).
44	HCPCS Rates	Enter the CPT/HCPCS code for the service
45	Service date	The date the indicated service was provided
46	Service units	A quantitative measure of services rendered by revenue category to or for the client to include items such as number of accommodation days, miles, pints of blood, renal dialysis treatments, etc. Must be appropriate for the procedure code, if listed.
47	Total charges	Total charges (covered and non-covered) for this line.
50	Payer	The entries in this form locator correspond with the entries in form locators 39-41. See the *Billing Procedures* chapter, *Billing with multiple payers* section in this manual.
51	Provider number	Enter the provider's TPL and Medicaid ID numbers
54	Prior payments	The amount the provider has received toward payment of this bill
58	Insured's name	Name of the individual in whose name the insurance is carried
60	Cert - SSN - HIC - ID #	Client's Medicaid ID number
63*	Treatment auth. code	Enter the prior authorization code for the service. This form locator is required for all out-of-state billers an some in-state services.
67-75	Principal diagnosis code	Use the ICD-9-CM code for the principal diagnosis. Enter additional diagnoses codes in form locators 68-75
76	Admitting diagnosis code	The ICD-9-CM code for the client's diagnosis or reason for visit
78	Unlabeled field	Enter applicable cost sharing indicator code (see *PASSPORT and Cost Sharing Indicators* earlier in this chapter)
82	Attending physician ID	For non-emergency outpatient services, enter the referring physician's Medicaid ID number. For emergency services, enter the emergency department physician's Medicaid ID number
85-86	Provider representative signature and date	An authorized signature and date indicating that the information entered on the face of this bill is in conformance with the certifications of the back of this bill

* Required if applicable

Client Has Medicaid and Third Party Liability Coverage

APPROVED OMB NO. 0938-0279

ST11843 1PLY UB-92

1 Take Time Medical Center 104 Time Square Anytown, MT 12345	2			3 PATIENT CONTROL NO. 4806					4 TYPE OF BILL 711	
5 FED. TAX NO.	6 STATEMENT COVERS PERIOD FROM 02/01/06	THROUGH 02/01/06	7 COV D.	8 N-C D.	9 C-I D.	10 L-R D.	11 9989888			

12 PATIENT NAME	13 PATIENT ADDRESS
Flower, Sammy L.	33 Flower Lane Buds, MT 59000

14 BIRTHDATE	15 SEX	16 MS	ADMISSION 17 DATE	18 HR	19 TYPE	20 SRC	21 D HR	22 STAT	23 MEDICAL RECORD NO.	CONDITION CODES 24	25	26	27	28	29	30	31
02/24/99	M		02/01/06	10		1		01									

	32 CODE	32 OCCURRENCE DATE	33 CODE	33 OCCURRENCE DATE	34 CODE	34 OCCURRENCE DATE	35 CODE	35 OCCURRENCE DATE	36 CODE	36 OCCURRENCE SPAN FROM	THROUGH	37
a												A
b												B
												C

38

	39 VALUE CODES CODE	AMOUNT	40 VALUE CODES CODE	AMOUNT	41 VALUE CODES CODE	AMOUNT	
a							a
b							b
c							c
d							d

	42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATES	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49	
1	521	Psy Dx Interview	90801	02/01/06	1	539.00			1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23						539.00			23

	50 PAYER	51 PROVIDER NO.	52 REL INFO	53 ASG BEN	54 PRIOR PAYMENTS	55 EST. AMOUNT DUE	56	
A	Double Indemnity Insurance	340367			231.42			A
B	Medicaid	0413213						B
C								C
	57		DUE FROM PATIENT ▶					

	58 INSURED'S NAME	59 P. REL	60 CERT. - SSN - HIC. - ID NO.	61 GROUP NAME	62 INSURANCE GROUP NO.	
A	Flower, Bud		432701763			A
B	Flower, Sammy L.		134638752			B
C						C

	63 TREATMENT AUTHORIZATION CODES	64 ESC	65 EMPLOYER NAME	66 EMPLOYER LOCATION	
A					A
B					B
C					C

67 PRIN. DIAG. CD.	OTHER DIAG. CODES 68 CODE	69 CODE	70 CODE	71 CODE	72 CODE	73 CODE	74 CODE	75 CODE	76 ADM. DIAG. CD.	77 E-CODE	78
314.01									314.01		

79 P.C.	80 PRINCIPAL PROCEDURE CODE	DATE	81 OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	82 ATTENDING PHYS. ID
			A		B		E06674 Dr. Thorne
	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	OTHER PROCEDURE CODE	DATE	83 OTHER PHYS. ID
	C		D		E		A

	84 REMARKS	OTHER PHYS. ID	
a			a
b		B	b
c			
d			

85 PROVIDER REPRESENTATIVE: X Linda Letters

86 DATE: 02/20/06

UB-92 HCFA-1450 OCR/ORIGINAL

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

UB-92 Agreement

Your signature on the UB-92 constitutes your agreement to the terms presented on the back of the form. This form is subject to change by the Centers for Medicare and Medicaid Services (CMS).

UNIFORM BILL: **NOTICE: ANYONE WHO MISREPRESENTS OR FALSIFIES ESSENTIAL INFORMATION REQUESTED BY THIS FORM MAY UPON CONVICTION BE SUBJECT TO FINE AND IMPRISONMENT UNDER FEDERAL AND/OR STATE LAW.**

Certifications relevant to the Bill and Information Shown on the Face Hereof: Signatures on the face hereof incorporate the following certifications or verifications where pertinent to this Bill:

1. If third party benefits are indicated as being assigned or in participation status, on the face thereof, appropriate assignments by the insured/beneficiary and signature of patient or parent or legal guardian covering authorization to release information are on file. Determinations as to the release of medical and financial information should be guided by the particular terms of the release forms that were executed by the patient or the patient's legal representative. The hospital agrees to save harmless, indemnify and defend any insurer who makes payment in reliance upon this certification, from and against any claim to the insurance proceeds when in fact no valid assignment of benefits to the hospital was made.

2. If patient occupied a private room or required private nursing for medical necessity, any required certifications are on file.

3. Physician's certifications and re-certifications, if required by contract or Federal regulations, are on file.

4. For Christian Science Sanitoriums, verifications and if necessary re-verifications of the patient's need for sanitorium services are on file.

5. Signature of patient or his/her representative on certifications, authorization to release information, and payment request, as required be Federal law and regulations (42 USC 1935f, 42 CFR 424.36, 10 USC 1071 thru 1086, 32 CFR 199) and, any other applicable contract regulations, is on file.

6. This claim, to the best of my knowledge, is correct and complete and is in conformance with the Civil Rights Act of 1964 as amended. Records adequately disclosing services will be maintained and necessary information will be furnished to such governmental agencies as required by applicable law.

7. For Medicare purposes:

   If the patient has indicated that other health insurance or a state medical assistance agency will pay part of his/her medical expenses and he/she wants information about his/her claim released to them upon their request, necessary authorization is on file. The patient's signature on the provider's request to bill Medicare authorizes any holder of medical and non-medical information, including employment status, and whether the person has employer group health insurance, liability, no-fault, workers' compensation, or other insurance which is responsible to pay for the services for which this Medicare claim is made.

8. For Medicaid purposes:

   This is to certify that the foregoing information is true, accurate, and complete.
   I understand that payment and satisfaction of this claim will be from Federal and State funds, and that any false claims, statements, or documents, or concealment of a material fact, may be prosecuted under applicable Federal or State Laws.

9. For CHAMPUS purposes:

   This is to certify that:

   (a) the information submitted as part of this claim is true, accurate and complete, and, the services shown on this form were medically indicated and necessary for the health of the patient;

   (b) the patient has represented that by a reported residential address outside a military treatment center catchment area he or she does not live within a catchment area of a U.S. military or U.S. Public Health Service medical facility, or if the patient resides within a catchment area of such a facility, a copy of a Non-Availability Statement (DD Form 1251) is on file, or the physician has certified to a medical emergency in any assistance where a copy of a Non-Availability Statement is not on file;

   (c) the patient or the patient's parent or guardian has responded directly to the provider's request to identify all health insurance coverages, and that all such coverages are identified on the face the claim except those that are exclusively supplemental payments to CHAMPUS-determined benefits;

   (d) the amount billed to CHAMPUS has been billed after all such coverages have been billed and paid, excluding Medicaid, and the amount billed to CHAMPUS is that remaining claimed against CHAMPUS benefits;

   (e) the beneficiary's cost share has not been waived by consent or failure to exercise generally accepted billing and collection efforts; and,

   (f) any hospital-based physician under contract, the cost of whose services are allocated in the charges included in this bill, is not an employee or member of the Uniformed Services. For purposes of this certification, an employee of the Uniformed Services is an employee, appointed in civil service (refer to 5 USC 2105), including part-time or intermittent but excluding contract surgeons or other personnel employed by the Uniformed Services through personal service contracts. Similarly, member of the Uniformed Services does not apply to reserve members of the Uniformed Services not on active duty.

   (g) based on the Consolidated Omnibus Budget Reconciliation Act of 1986, all providers participating in Medicare must also participate in CHAMPUS for inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

   (h) if CHAMPUS benefits are to be paid in a participating status, I agree to submit this claim to the appropriate CHAMPUS claims processor as a participating provider. I agree to accept the CHAMPUS-determined reasonable charge as the total charge for the medical services or supplies listed on the claim form. I will accept the CHAMPUS-determined reasonable charge even if it is less than the billed amount, and also agree to accept the amount paid by CHAMPUS, combined with the cost-share amount and deductible amount, if any, paid by or on behalf of the patient as full payment for the listed medical services or supplies. I will make no attempt to collect from the patient (or his or her parent or guardian) amounts over the CHAMPUS-determined reasonable charge. CHAMPUS will make any benefits payable directly to me, if I submit this claim as a participating provider.

ESTIMATED CONTRACT BENEFITS

Avoiding Claim Errors

Claims are often denied or even returned to the provider before they can be processed. To avoid denials and returns, double check each claim form to confirm the following items are accurate. For more information on returned and denied claims, see the *Billing Procedures* chapter in this manual.

Common Claim Errors

Claim Error	Prevention
Required form locator is blank	Check the claim instructions earlier in this chapter for required form locators. If a required form locator is blank, the claim may either be returned or denied.
Client ID number missing or invalid	This is a required form locator (FL 60); verify that the client's Medicaid ID number is listed as it appears on the client's eligibility verification (see the *General Information For Providers, Client Eligibility* chapter).
Client name missing	This is a required form locator (FL 12); check that it is correct.
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the claim (FL 51).
PASSPORT provider name and ID number missing	When services are not provided by the client's PASSPORT provider, include the provider's PASSPORT number (FL 11) (see the *PASSPORT and Prior Authorization* chapter in this manual).
Prior authorization number missing	When prior authorization (PA) is required for a service, the PA number must be listed on the claim in FL 63 (see *PASSPORT and Prior Authorization* in this manual).
Not enough information regarding other coverage	Form locators 39-41, 50, and in some cases 54, are required when a client has other coverage (refer to the examples earlier in this chapter).
Authorized signature missing	Each claim must have an authorized signature belonging to the provider, billing clerk, or office personnel. The signature may be typed, stamped, or hand-written.
Signature date missing	Each claim must have a signature date.
Incorrect claim form used	Services covered in this manual require a UB-92 claim form.
Information on claim form not legible	Information on the claim form must be legible. Use dark ink and center the information in the form locator. Information must not be obscured by lines.

Other Programs

MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*). The information in this chapter does not apply to clients enrolled in the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

Remittance Advice Description

The remittance advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous remittance advice cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* later in this chapter). Each line of the remittance advice represents all or part of a claim, and explains whether the claim has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason. See the sample RA on the following page.

RA notice

The RA notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that affect providers and claims.

Paid claims

This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the provider having to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).

Denied claims

This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark Codes column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter. Please make necessary changes to the claim before rebilling Medicaid.

If a claim was denied, read the description of the reason and remark code before taking any action on the claim.

Pending claims

All claims that have not reached final disposition will appear in this area of the RA. The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied.

The pending claims section of the RA is informational only. Do not take any action on the claims shown here.

Sample Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604
REMITTANCE ADVICE FOR MEDICAID/CHIP/MHSP (1)

COMMUNITY CLINIC
2100 NORTH MAIN STREET
CENTRAL CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 654321 (5) DATE:02/15/05 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	010305	010305	1	521	58.90	11.78	N	
(9) ICN	00204011350000700								
		LESS MEDICARE PAID*******					93.02	(17)	
		LESS COPAY DEDUCTION**							
		CLAIM TOTAL*******				58.90			
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020105	020105	1	521	325.50	0.00	Y	
ICN	00204011350000800				(16)				
		020305	020305	1	521	539.00	0.00 (17)	N	
		CLAIM TOTAL*******				864.50	0.00		31 MA61
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	020405	020405	1	521	810.00	0.00 (17)	N	31
ICN	00204011350000900								
		CLAIM TOTAL*******				810.00			

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APPEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key Fields on the Remittance Advice

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider by Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or point-of-sale (POS) pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day, the same date will appear in both columns
11. Unit of service	The units of service rendered under this procedure, NDC code or revenue code.
12. Procedure/revenue/NDC	The procedure code (CPT, HCPCS, or local), National Drug Code (NDC), or revenue code will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Copay	A "Y" indicates cost sharing was deducted from the allowed amount, and an "N" indicates cost sharing was not deducted.
16. Reason/Remark code	A code which explains why the service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, billed amount, and paid amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.

Credit balances

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

The credit balance section is informational only. Do not post from credit balance statements.

Credit balances can be resolved in two ways:

1. By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
2. By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

Medicaid does not accept any claim for resubmission or adjustment after 12 months from the date of service (see *Timely Filing Limits* in *Billing Procedures* chapter).

How long do I have to rebill or adjust a claim?

- Providers may resubmit or adjust any initial claim within the timely filing limits described in the *Billing Procedures* chapter of this manual.
- These time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check or requesting Provider Relations (see *Credit balances* #2 above) to complete a gross adjustment.

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* and *Completing a Claim* chapters.

When to rebill Medicaid

Rebill denied claims only after appropriate corrections have been made.

- ***Claim Denied.*** Providers can rebill Medicaid when a claim is denied in full, as long as the claim was denied for reasons that can be corrected. When the entire claim is denied, check the reason and remark code, make the appropriate corrections, and resubmit the claim on a UB-92 form (not the adjustment form).
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit your claim.

How to rebill

- Check any reason and remark code listed and make your corrections on a copy of the claim, or produce a new claim with the correct information.
- Enter any insurance (TPL) information on the corrected claim, or attach insurance denial information to the corrected claim, and send it to Claims Processing (see *Key Contacts*).

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see the *Billing Procedures* chapter, *Claim Inquiries*). Once an incorrect payment has been verified, the provider may submit an *Individual Adjustment Request* form (in *Appendix A*) to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th

Adjustments can only be made to paid claims.

digit will be a 2, indicating an adjustment. See *Key Fields on the Remittance Advice* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when a claim was overpaid or underpaid.
- Request an adjustment when a claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).
- Request an adjustment when a single line on a multi-line claim was denied.

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Claims Processing must receive individual claim adjustment requests within 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section of the adjustment form.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*. You may also order forms from Provider Relations or download them from the Provider Information website (see *Key Contacts*). Complete Section A first with provider and client information and the claim's ICN number (see following table and sample RA).
2. Complete Section B with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
   - Enter the date of service or the line number in the *Date of Service or Line Number* column.
   - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
   - Enter the correct information in the column labeled *Corrected Information*.

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider name and address	Provider's name and address (and mailing address if different).
2. Recipient name	The client's name is here.
3.* Internal control number (ICN)	There can be only one ICN per adjustment request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid number	Client's Medicaid ID number.
6. Date of payment	Date claim was paid is found on remittance advice field #5 (see the sample RA earlier in this chapter).
7. Amount of payment	The amount of payment from the remittance advice field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure code/ NDC/ Revenue code	If the procedure code, NDC, or revenue code is incorrect, complete this line.
3. Dates of service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed amount	If the billed amount is incorrect, complete this line.
5. Personal resource (Nursing facility)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance credit amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount third party liability or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

3. Attach copies of the RA and a corrected claim if necessary.
   - If the original claim was billed electronically, a copy of the RA will suffice.
   - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:
This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS Community Clinic Name 123 Medical Drive Street or P.O. Box Anytown, MT 59999 City State Zip	3. INTERNAL CONTROL NUMBER (ICN) 00204011250000600 4. PROVIDER NUMBER 1234567 5. CLIENT ID NUMBER 123456789
2. CLIENT NAME Jane Doe	6. DATE OF PAYMENT 02/15/05 7. AMOUNT OF PAYMENT $ 11.49

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service	Line 2	2	1
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)	Line 3	02/01/05	01/23/05
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: John R. Smith, M.D. DATE: 04/15/05

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604

Sample Adjustment Request

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount through a credit. If the result is a credit balance, it can be worked off or the provider can pay off the balance by check (see *Credit balances* earlier in this chapter).
- Any questions regarding claims or adjustments must be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section). Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and the RA

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

Electronic Funds Transfer

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. See *Direct Deposit Arrangements* under *Key Contacts* for questions or changes regarding EFT.

Electronic Remittance Advice

To receive an electronic RA, the provider must complete the *Electronic Remittance Advice and Payment Cycle Enrollment Form* (see the following table), have internet access, and be registered for the Montana Access to Health Web Portal. You can access your electronic RA through the Web Portal on the internet by going to the Provider Information website (see *Key Contacts*) and selecting Provider Services. In order to access the Montana Access to Health Web Portal, you must first complete an *EDI Provider Enrollment Form* and an *EDI Trading Partner Agreement* (see the following table).

Electronic RAs are available for only 90 days on the web portal.

After these forms have been processed, you will receive a user ID and password that you can use to log on to the Web Portal. The verification process also requires a provider ID, a submitter ID, and a tax ID number. Each provider must complete an *EDI Trading Partner Agreement,* but if there are several providers in one location who are under one tax ID number, they can use one submitter number. These providers should enter the submitter ID in both the provider number and submitter ID fields. Otherwise, enter the provider number in the provider number field.

RAs are available in PDF format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the Web Portal home page. Due to space limitations, each RA is only available for 90 days.

Required Forms for EFT and/or Electronic RA

All four forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows providers to receive electronic remittance advices on the Montana Access to Health Web Portal (must also include an EDI Provider Enrollment Form and EDI Trading Partner Agreement)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
EDI Provider Enrollment Form and EDI Trading Partner Agreement	Allow provider to access their RA on the Montana Access to Health Web Portal (must also include an Electronic Remittance Advice and Payment Cycle Enrollment Form)	• Provider Information website • ACS EDI Gateway website (see *Key Contacts)*	ACS address on the form

Other Programs

MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*). The information in this chapter does not apply to clients enrolled in the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

How Payment Is Calculated

Overview

Though providers do not need the information in this chapter to submit claims to the Department, the information allows providers to understand how payment is calculated and to predict approximate payment for particular claims.

RHCs and FQHCs

RHCs and FQHCs are reimbursed for their costs of providing care using a prospective payment system. This payment allows for one all-inclusive rate of payment per visit, regardless of procedure or diagnosis. This payment is the same for core, other ambulatory and billable incident-to services. For example, you will receive the same payment for an office visit to fill a cavity or fix a broken leg. This payment method applies to provider-based and independent RHCs and FQHCs.

The Prospective Payment System

RHCs and FQHCs began being reimbursed on a prospective payment system on January 1, 2001. Reimbursement is made per ARM 47.86.4401 - 47.86.4420.

If you have questions about how your payment rate is calculated, please contact the RHC and FQHC program officer.

Reimbursement Rates for Increase or Decrease in Scope of Service

An increase or decrease in the scope of service means the addition or deletion of a service or a change in the magnitude, intensity or character of services provided by a clinic or one of their sites. The increase or decrease in the scope of service must reasonably be expected to last at least one year. The term includes but is not limited to:

- An increase or decrease in intensity attributable to changes in the types of patients served, including but not limited to HIV/AIDS, the homeless, elderly, migrant or other chronic diseases or special populations;
- Any changes in services or provider mix provided by a clinic or one of their sites;

- Increases or decreases in operating costs that have occurred during the fiscal year and that are attributable to capital expenditures, including new service facilities or regulatory compliance; and
- Any approved changes in scope of project as defined by the Health Resources and Service Administration (HRSA).

A clinic must notify the department, in writing, of an increase or decrease in the scope of service offered by the clinic. Upon the request of a clinic, the department will determine if a change qualifies as an increase or decrease in the scope of service, and if so, the amount and effective date of any rate increase or decrease.

How Payment Is Calcluated

TPL claims

When a client has coverage from both Medicaid and another insurance company, the other insurance company is often referred to as Third Party Liability or TPL. In these cases, the other insurance is the primary payer (as described in the *Coordination of Benefits* chapter of this manual), and Medicaid makes a payment as the secondary payer. Medicaid will make a payment only when the TPL payment is less than the Medicaid allowed amount.

For example, a provider submits an RHC or FQHC claim for $120.00 for a client with Medicaid and TPL. The Medicaid allowed amount is $106.58. The other insurance company paid $95.05. This amount is subtracted from the Medicaid allowed amount leaving $11.53. Medicaid pays $11.53 for this claim. If the TPL payment had been $106.58 or more, this claim would have paid at $0.00.

Medicare crossover claims for RHCs

When an RHC client has coverage from both Medicare and Medicaid, Medicare is the primary payer. Medicaid will pay the coinsurance and deductible, less any TPL or incurment, on RHC claims for these dually eligible individuals.

For example, a RHC provider submits a claim for a client with Medicare and Medicaid. The Medicare coinsurance and deductible total $11.78. This total ($11.78) becomes the Medicaid allowed amount. Medicaid will pay this amount ($11.78) as long as no TPL or incurment amounts are applicable.

Medicare crossover claims for FQHCs

When an FQHC client has coverage from both Medicare and Medicaid, Medicare is the primary payer, but any Medicare payment is treated like a TPL payment. Medicaid will make a payment only when the Medicare payment is less than the Medicaid allowed amount.

For example, an FQHC provider submits a claim for $55 for a client with Medicare and Medicaid. The Medicaid allowed amount is $106.58. Medicare paid $75.58. This amount is subtracted from the Medicaid allowed amount leaving $31.00. Medicaid pays $31.00 for this claim. If the Medicare payment had been $106.58 or more, this claim would have paid at $0.00.

Other Programs

MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*). The information in this chapter does not apply to clients enrolled in the Children's Health Insurance Plan (CHIP). The CHIP Medical Manual is available through BlueCross BlueShield at (800) 447-7828 X8647.

Appendix A: Forms

- ***Montana Medicaid/MHSP/CHIP Individual Adjustment Request***
- ***Medicaid Abortion Certification***
- ***Informed Consent to Sterilization (MA-38)***
- ***Medicaid Hysterectomy Acknowledgment (MA-39)***
- ***Montana Medicaid Claim Inquiry Form***

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City State Zip

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: ACS
P.O. Box 8000
Helena, MT 59604

MA-037
(REV 08/98)

MEDICAID RECIPIENT/PHYSICIAN ABORTION CERTIFICATION

MEDICAID CLAIMS FOR ABORTION SERVICES WILL NOT BE PAID UNLESS THIS FORM IS COMPLETED IN FULL AND A COPY IS ATTACHED TO THE MEDICAID CLAIM FORM.

Recipient Name:_____ Provider Name: _____

Part I, II or III must be completed and the physician completing the procedure must sign below.

I. IF THE ABORTION IS NECESSARY TO SAVE THE RECIPIENT'S LIFE, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, recipient suffers from a physical disorder, physical injury or physical illness (or life-endangering physicial condition caused by or arising from the pregnancy itself) that would place the recipient in danger of death unless an abortion is performed.

(attach additional sheets as necessary)

II. IF THE PREGNANCY RESULTED FROM RAPE OR INCEST, THE FOLLOWING MUST BE COMPLETED BY THE RECIPIENT AND PHYSICIAN:

RECIPIENT CERTIFICATION: I Hereby certify that my current pregnancy resulted from an act of rape or incest.

PHYSICIAN CERTIFICATION: If the pregnancy resulted from rape or incest, the physician must mark one of the following and sign below:

___ a. The recipient has stated to me that she has reported the rape or incest to a law enforcement or protective services agency having jurisdiction in the matter or, if the patient is a child enrolled in a school, to a school counselor; or

___ b. Based upon my professional judgement, the recipient was and is unable for physical or psychological reasons to report the act of rape or incest.

III. IF THE ABORTION IS MEDICALLY NECESSARY BUT THE RECIPIENT'S LIFE IS NOT IN DANGER, THE FOLLOWING MUST BE COMPLETED BY THE PHYSICIAN:

In my professional opinion, an abortion is medically necessary for the following reasons:

(attach additional sheets as necessary)

PHYSICIAN SIGNATURE: _____ DATE: _____

THE INFORMATION CONTAINED IN THIS FORM IS CONFIDENTIAL. THIS INFORMATION IS PROVIDED FOR PURPOSES RELATED TO ADMINISTRATION OF THE MEDICAID PROGRAM AND MAY NOT BE RELEASED FOR ANY OTHER PURPOSE WITHOUT THE WRITTEN CONSENT OF THE RECIPIENT.

DPHHS-MA-38
(Rev. 8/98)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES
INFORMED CONSENT TO STERILIZATION

Medicaid Approved

NOTICE: YOUR DECISION AT ANY TIME NOT TO BE STERILIZED WILL NOT RESULT IN THE WITHDRAWAL OR WITHHOLDING OF ANY BENEFITS PROVIDED BY PROGRAMS OR PROJECTS RECEIVING FEDERAL FUNDS.

CONSENT TO STERILIZATION

I have asked for and received information about sterilization from _____. When I first asked for
(Doctor or Clinic)
the information, I was told that the decision to be sterilized is completely up to me. I was told that I could decide not to be sterilized. If I decide not to be sterilized, my decision will not affect my right to future care to treatment. I will not lose any help or benefits from programs receiving Federal funds, such as AFDC or Medicaid that I am now getting or for which I may become eligible.

I UNDERSTAND THAT THE STERILIZATION MUST BE CONSIDERED **PERMANENT** AND **NOT REVERSIBLE**. I HAVE DECIDED THAT I DO NOT WANT TO BECOME PREGNANT, BEAR CHILDREN OR FATHER CHILDREN.

I was told about those temporary methods of birth control that are available and could be provided to me which will allow me to bear or father a child in the future. I have rejected those alternatives and chosen to be sterilized.

I understand that I will be sterilized by an operation known as a _____. The discomforts, risks and benefits associated with the operation have been explained to me. All my questions have been answered to my satisfaction.

I understand that the operation will not be done until at least thirty days after I sign this form. I understand that I can change my mind at any time and that my decision at any time not to be sterilized will not result in the withholding of any benefits or medical services provided by Federally funded programs.

I am at least 21 years of age and was born on _____
(month) (day) (year)
I, _____, hereby consent of my own free will to be sterilized by _____
(Doctor)
by a method called _____. My consent expires 180 days from the date of my signature below.

I also consent to the release of this form and other medical records about the operation to:

Representatives of the Department of Health & Human Services or Employees of programs or projects funded by that department but only for determining if Federal laws were observed.

I have received a copy of this form.

_____
(Signature) **(Date)**

You are requested to supply the following information, but it is not required. *Race and ethnicity designation (please check):*

- ☐ American Indian or Alaskan Native
- ☐ Asian or Pacific Islander
- ☐ Black (not of Hispanic origin)
- ☐ Hispanic
- ☐ White (not of Hispanic origin)

INTERPRETER'S STATEMENT

If an interpreter is provided to assist the individual to be sterilized:

I have translated the information and advice presented orally to the individual to be sterilized by the person obtaining this consent. I have also read him/her the consent form in _____ language and explained its contents to him/her. To the best of my knowledge and belief he/she understood this explanation.

_____
(Interpreter) **(Date)**

STATEMENT OF PERSON OBTAINING CONSENT

Before _____ signed
(name of individual)
the consent form, I explained to him/her the nature of the sterilization operation _____, the fact that it is intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or any benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is as least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appears to understand the nature and consequences of the procedure.

_____
(Signature of person obtaining consent) **(date)**

_____
(Facility)

_____
(Address)

PHYSICIAN'S STATEMENT

Shortly before I performed a sterilization operation upon
_____
(Name of person being sterilized)
on _____
(date of sterilization operation)
I explained to him/her the nature of the sterilization operation _____, the fact that it is
(specify type of operation)
intended to be a final and irreversible procedure and the discomforts, risks and benefits associated with it.

I counseled the individual to be sterilized that alternative methods of birth control are available which are temporary. I explained that sterilization is different because it is permanent.

I informed the individual to be sterilized that his/her consent can be withdrawn at any time and that he/she will not lose any health services or benefits provided by Federal funds.

To the best of my knowledge and belief, the individual to be sterilized is at least 21 years old and appears mentally competent. He/she knowingly and voluntarily requested to be sterilized and appeared to understand the nature and consequences of the procedure

(Instructions for use of alternative final paragraphs: Use the first paragraph below except in the case of premature delivery or emergency abdominal surgery where the sterilization is performed less than 30 days after the date of the individual's signature on the consent form. In those cases, the second paragraph below must be used. Cross out the paragraph which is not used.)

(1) At lease thirty days have passed between the date of the individual's signature on this consent form and the date the sterilization was performed.

(2) This sterilization was performed less than 30 days but more than 72 hours after the date of the individual's signature on this consent form because of the following circumstances (check applicable box and fill in information requested):

- ☐ Premature delivery
- ☐ Individual's expected date of delivery: _____
- ☐ Emergency abdominal surgery:

(describe circumstances):_____
_____

_____
(Physician) **(Date)**

DISTRIBUTION: 1 - patient; 1 - provider (physician, hospital, etc.); 1 - fiscal agent with claim

Instructions for Completing the *Informed Consent to Sterilization* (MA-38)

- No fields on this form may be left blank, except the interpreter's statement.
- This form must be legible, accurate, and revisions are not accepted.
- Do not use this form for hysterectomies (see following *Hysterectomy Acknowledgment* form.)

Consent to Sterilization (complete at least 30 days prior to procedure)

1. Enter the doctor's name or clinic name.
2. Enter the name of the sterilization procedure (e.g., tubal ligation, vasectomy, etc.).
3. Enter the client's date of birth in month/day/year format. The client must be at least 21 years old at the time of consent.
4. Enter the client's full name. Do not use nicknames. The name should match the client's name on the Medicaid ID card.
5. Enter the name of the physician who will perform the procedure.
6. Enter the name of the specific procedure (method) to be used.
7. Have the client sign and date the form. **This date must be at least 30 days before the sterilization procedure is to be performed** (see *Covered Services* for exceptions).

Interpreter's Statement

Complete this section only if the client requires an interpreter because of blindness, deafness, or inability to speak the language. In these cases interpreter services must be used to assure that the client clearly understands the concepts of the informed consent.

1. Identify the manner the interpreter used to provide the explanation. (e.g., Spanish, sign language, etc.)
2. Have the interpreter sign and date the form. This date should be the same as the date the client signs the form.

Statement of Person Obtaining Consent

1. Enter the client's name.
2. Enter the name of the sterilization procedure.
3. Enter the signature and date of the person who explained the sterilization procedure to the client and obtained the consent.
4. Enter the name of the facility where consent was obtained, such as clinic name.
5. Enter the address of the facility where the consent was obtained.

Physician's Statement

This section must be completed by the attending physician on or after the date the procedure was performed.

1. Enter the name of the client.
2. Enter the date the procedure was performed. This date and the date of service on the claim must match.
3. Enter the name of the procedure.
4. Use the space under *Instructions for use of alternative final paragraphs* to explain unusual situations, or attach a letter to explain the circumstances. In cases of premature delivery, this must include the client's expected date of delivery. In cases of emergency abdominal surgery, include an explanation of the nature of the emergency.
5. The Physician signs and dates on or after the date of the procedure.

If the physician signs and dates this section prior to the sterilization procedure, the claims will be denied. If the form was filled out after the sterilization but was dated incorrectly, the physician must attach a written explanation of the error. This written explanation must be signed by the physician. Copies of the letter will need to be supplied to all other providers involved with this care before their claims will be paid.

The attending physician must complete the second *alternative final paragraphs* of the Physician's Statement portion of the consent form in cases of premature deliver or emergency abdominal surgery. In cases of premature delivery, the expected delivery date must be completed in this field as well.

DPHHS-MA-039
(Rev. 9/05)

STATE OF MONTANA
DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

MEDICAID HYSTERECTOMY ACKNOWLEDGMENT

A. RECIPIENT ACKNOWLEDGMENT STATEMENT

I certify that prior to the surgery (hysterectomy), I received both orally and in writing information which explained that I would become permanently sterile and that I would be incapable of reproducing children after the surgery is completed.

Signature of Recipient: _____ Date: _____

Signature of Representative (If Required):_____ Date: _____

PHYSICIAN ACKNOWLEDGMENT STATEMENT

I certify that prior to performing the surgery, I advised _____ *(Name of Recipient)* both orally and in writing that the surgical procedure known as a hysterectomy would render her permanently sterile and that she would be incapable of reproducing children after the surgical procedure is completed. I also certify that this procedure is being done primarily for medical reasons other than sterilization.

Signature of Physician: _____ Date: _____

SIGNATURE OF INTERPRETER (If Required)

Signature of Interpreter: _____ Date: _____

B. STATEMENT OF PRIOR STERILITY

I certify that _____ *(Name of Recipient)* was already sterile and unable to bear children at the time the hysterectomy or other procedure capable of causing sterility was performed. The cause of this recipient's sterility was: _____

_____

_____

Signature of Physician: _____ Date: _____

C. STATEMENT OF LIFE THREATENING EMERGENCY

I certify that the hysterectomy or other sterility causing procedure performed on _____ *(Name of Recipient)* was completed under a life threatening emergency situation in which prior acknowledgment was not possible. The nature of the emergency was _____

_____

_____

Signature of Physician: _____ Date: _____

This form may also be used as a substitute for the sterilization consent form for sterilization procedures where the patient is already sterile and for sterilization procedures (i.e., salpingo-oophorectomy, orchiectomy) done only for medical reasons. With these cases, replace "hysterectomy" with the appropriate procedure name.

Instructions for Completing the *Medicaid Hysterectomy Acknowledgment* Form (MA-39)

Complete only one section (A, B, or C) of this form. The client does not need to sign this form when sections B or C are used. This form may be used as a substitute for the *Informed Consent to Sterilization* form for sterilization procedures where the client is already sterile, and for sterilization procedures (i.e. salpingo-oophorectomy, orchiectomy, etc.) done only for medical reasons. In these cases, replace the word "hysterectomy" with the appropriate procedure name.

A. Recipient Acknowledgment Statement

This section is used to document that the client received information about the hysterectomy (or other sterilization-causing procedure such as salpingo-oophorectomy or orchiectomy) before it was performed. The client and the physician must complete this portion of the form together (with an interpreter if applicable) prior to the procedure. Do **not** use this section for cases of prior sterility or life-threatening emergency.

1. The client or representative must sign and date the form prior to the procedure.
2. Enter the client's name.
3. The physician must sign and date the form prior to the procedure.
4. If interpreter services are used, the interpreter must sign and date the form prior to the procedure.

B. Statement of Prior Sterility

Complete this section if the client was already sterile at the time of her hysterectomy or other sterilization causing procedure (e.g., salpingo-oophorectomy or orchiectomy).

1. Enter the client's name.
2. Explain the cause of the client's sterility (e.g., post menopausal, post hysterectomy, etc.).
3. The physician must sign and date this portion of the form.

C. Statement of Life Threatening Emergency

Complete this section in cases where the *Medicaid Hysterectomy Acknowledgment* could not be completed prior to the surgery because of a life threatening emergency.

1. Enter the client's name.
2. Explain the nature of the life-threatening emergency.
3. The physician must sign and date this portion of the form.

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	
Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	
Provider number _____	ACS Response: _____
Client number _____	
Date of service _____	
Total billed amount _____	
Date submitted for processing _____	

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Allowed Amount
The maximum amount reimbursed to a provider for a health care service as determined by Medicaid or another payer. Other cost factors, (such as cost sharing, TPL, or incurment) are often deducted from the allowed amount before final payment. Medicaid's allowed amount for each covered service is listed on the Department fee schedule.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Assignment of Benefits
A voluntary decision by the client to have insurance benefits paid directly to the provider rather than to the client. The act requires the signing of a form for the purpose. The provider is not obligated to accept an assignment of benefits. However, the provider may require assignment in order to protect the provider's revenue.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than a partial month.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid programs. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
This plan covers some children whose family incomes make them ineligible for Medicaid. DPHHS sponsors the program, which is administered by BlueCross BlueShield of Montana.

Clean Claim
A claim that can be processed without additional information from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Code of Federal Regulations (CFR)
Rules published by executive departments and agencies of the federal government.

Coinsurance
The client's financial responsibility for a medical bill as assigned Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost Sharing
The client's financial responsibility for a medical bill assessed by flat fee or percentage of charges.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Medical Condition
A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part; or

With respect to a pregnant woman who is having contractions:

- That there is inadequate time to effect a safe transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or the unborn child.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Federally Qualified Health Center (FQHC)
An entity that has entered into an agreement with The Centers for Medicare and Medicaid Services (CMS) to meet Medicare program requirements and is receiving a grant under section 329, 330, or 340 of the Public Health Service Act or is receiving funding from such a grant under a contract with the recipient of

such a grant and meets the requirements to receive a grant under section 329, 330, or 340 of the Public Health Service Act. An FQHC may also be an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an Urban Indian Organization receiving funds under Title V of the Indian Health Care Improvement Act.

Fiscal Agent
ACS State Healthcare LLC is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Gross Adjustment
A lump sum debit or credit that is not claim specific made to a provider.

Homebound
Normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort

Independent entity
A rural health clinic or federally qualified health center that is not a provider-based entity.

Indian Health Service (IHS)
IHS provides health services to American Indians and Alaska Natives.

Individual Adjustment
A request for a correction to a specific paid claim.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) website that contains information on the topic specified.

Mass Adjustment
Request for a correction to a group of claims meeting specific defined criteria.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department. MHSP services are not allowed for RHCs and FQHCs. Providers will find more information on Medicaid mental health services and MHSP services in the *Mental Health* manual available on the Provider Information website (see *Key Contacts*).

Mentally Incompetent
According to CFR 441.251, a mentally incompetent individual means an individual who has been declared mentally incompetent by a federal, state, or local court of competent jurisdiction for any purpose, unless the individual has been declared competent for purposes which include the ability to consent to sterilization.

Minimal Services
According to CPT 2001, when client's visit does not require the presence of the physician, but services are provided under the physician's supervision, they are considered minimal services. An example would be a patient returning for a monthly allergy shot.

Montana Access to Health (MATH) Web Portal
A secure website on which providers may view clients' medical history, verify client eligibility, submit claims to Medicaid, check the status of a claim, verify the status of a warrant, and download remittance advice reports.

Montana Breast and Cervical Cancer Treatment Program
This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

Mutually Exclusive Code Pairs
These codes represent services or procedures that, based on either the CPT-4 definition or standard medical practice, would not or could not reasonably be performed at the same session by the same provider on the same patient. Codes representing these services or procedures cannot be billed together.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Protocols
Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must by updated and approved by a physician at least annually.

Provider
The entity enrolled in the Montana Medicaid program as a provider of RHC or FQHC services.

Provider-Based Entity
An FQHC or RHC that is an integral or subordinate part of a hospital, skilled nursing facility, or home health agency that is participating in the Medicare program and that is operated with other departments of the provider under the common licensure, governance and professional supervision.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Remittance Advice (RA)
The results of claims processing (including paid, denied, and pending claims) are listed on the RA.

Reporting Period
A period of 12 consecutive months specified by an RHC or FQHC as the period for which the entity must report its costs and utilization. The reporting period must correspond to the provider's fiscal year. The first and last reporting periods may be less than 12 months.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Routine Podiatric Care
Routine podiatric care includes the cutting or removing of corns and calluses, the trimming and debridement of nails, the application of skin creams, and other hygienic, preventive maintenance care.

Rural Health Clinic
A clinic located in a rural area designated as a shortage area by the Secretary of the U.S. Department of Health and Human Services to meet the rural health clinic conditions of certification specified in 42 CFR, part 491, subpart A.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary

The fee that the provider most frequently charges the general public for a service or item.

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